SERFF Tracking Number: ASWX-126478651 State: Arkansas State Tracking Number: Filing Company: 44723 Time Insurance Company

IHAR01145FIF01 Company Tracking Number:

TOI: Sub-TOI: H16G Group Health - Major Medical H16G.001C Any Size Group - Other

Product Name: Time Insurance-Base Chassis

Time Insurance-Base Chassis/IH AR01145FIF01 Project Name/Number:

# Filing at a Glance

Company: Time Insurance Company

Product Name: Time Insurance-Base Chassis SERFF Tr Num: ASWX-126478651 State: Arkansas

TOI: H16G Group Health - Major Medical SERFF Status: Closed-Approved- State Tr Num: 44723

Closed

Sub-TOI: H16G.001C Any Size Group - Other Co Tr Num: IHAR01145FIF01

State Status: Approved-Closed Filing Type: Form

Reviewer(s): Rosalind Minor

Author: SPI Disposition Date: 02/17/2010

AssurantHealthandEmployeeBenef

Date Submitted: 01/28/2010 Disposition Status: Approved-

Closed

Implementation Date Requested: 03/01/2010 Implementation Date:

State Filing Description:

## General Information

Project Name: Time Insurance-Base Chassis Status of Filing in Domicile: Project Number: IH AR01145FIF01

Date Approved in Domicile: Requested Filing Mode: Review & Approval **Domicile Status Comments:** 

Explanation for Combination/Other: Market Type:

Submission Type: New Submission Group Market Size: Overall Rate Impact: Group Market Type:

Filing Status Changed: 02/17/2010 Explanation for Other Group Market Type:

State Status Changed: 02/17/2010

Deemer Date: Created By: SPI

AssurantHealthandEmployeeBenef

Submitted By: SPI AssurantHealthandEmployeeBenef Corresponding Filing Tracking Number:

Filing Description:

TIME INSURANCE COMPANY (NAIC #69477; FEIN 39-0658730) RE:

Enrollment Form for Medical Insurance for Individuals and Families: 29300 (Rev. 1/2010)

Tele-App Part 1 Enrollment Form for Medical Insurance for Individuals and Families: 29400 (Rev. 1/2010) Tele-App Part 2 Enrollment Form for Medical Insurance for Individuals and Families: 29500 (Rev. 1/2010)

Preferred Rating Questionnaire: 26566 Amendment of Enrollment form: 30216

Dear Sir or Madam:

SERFF Tracking Number: ASWX-126478651 State: Arkansas
Filing Company: Time Insurance Company State Tracking Number: 44723

Company Tracking Number: IHAR01145FIF01

TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other

Product Name: Time Insurance-Base Chassis

Project Name/Number: Time Insurance-Base Chassis/IH AR01145FIF01

The above-referenced forms are submitted for your review and approval: Enrollment Form for Medical Insurance for Individuals and Families, 29300 (Rev. 1/2010), 29400 (Rev. 1/2010) and 29500 (Rev. 1/2010).

Form number 29300 is completed when an applicant is applying for coverage through the paper application process. The form series 29400 and 29500 are completed when an applicant is applying for coverage through the telephone application process, an online process or software based process.

Also enclosed are a Preferred Rating Questionnaire and an Amendment to the enrollment form. The amendment is used when the consumer wants to amend their response to a question on a previously completed application.

All forms are subject to minor modifications in paper size, stock, layout, format, company logo and printing specifications of the document upon issue. As mentioned above, some of the provisions/sections are bracketed to provide flexibility as well as to afford future flexibility to adjust to changing regulatory and market needs. Please see the enclosed Statement of Variability for additional information on form adaptability.

Upon approval, the amended forms will be used to market major medical insurance to individuals by independent agents licensed in your state.

Please note that Wisconsin is the state domicile for Time Insurance Company. The state of Wisconsin does not require the filing of forms that are being marketed for out-of-state use with their office.

Thank you in advance for your time and attention to this filing. Should you have any questions, or require additional information, please contact me at any of the numbers listed below.

Best Regards,

Christine R. Fleming
Senior Contract Compliance Analyst
Legal Department
christine.fleming@assurant.com
T 414.299.1306 or 800.800.1212 ext. 1306
F 414.299.6168

Company Tracking Number: IHAR01145FIF01

TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other

Product Name: Time Insurance-Base Chassis

Project Name/Number: Time Insurance-Base Chassis/IH AR01145FIF01

# **Company and Contact**

## **Filing Contact Information**

Christine Fleming, Senior Contract Compliance christine.fleming@assurant.com

Analyst

501 W. Michigan St. 414-299-1306 [Phone] 1306 [Ext]

Milwaukee, WI 53203 414-299-6168 [FAX]

**Filing Company Information** 

Time Insurance Company CoCode: 69477 State of Domicile: Wisconsin

501 W. Michigan St. Group Code: 19 Company Type:
Milwaukee, WI 53203 Group Name: State ID Number:

(800) 800-1212 ext. [Phone] FEIN Number: 39-0658730

-----

# **Filing Fees**

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No

Fee Explanation:

Per Company: No

COMPANY AMOUNT DATE PROCESSED TRANSACTION #

Time Insurance Company \$50.00 01/28/2010 33862874

Company Tracking Number: IHAR01145FIF01

TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other

Product Name: Time Insurance-Base Chassis

Project Name/Number: Time Insurance-Base Chassis/IH AR01145FIF01

# **Correspondence Summary**

## **Dispositions**

Status	Created By	Created On	Date Submitted
Approved- Closed	Rosalind Minor	02/17/2010	02/17/2010

**Objection Letters and Response Letters** 

Objection	Letters			Response Letters	S	
Status	Created By	<b>Created On</b>	<b>Date Submitted</b>	Responded By	Created On	<b>Date Submitted</b>
Pending	Rosalind Mino	or 02/02/2010	02/02/2010	SPI	02/17/2010	02/17/2010
Industry				AssurantHealthan		
Response				dEmployeeBenef		

**Filing Notes** 

Subject	Note Type	Created By	Created On	Date Submitted
TIME LIMIT TO RESPOND	Note To Filer	Rosalind Minor	02/12/2010	0 02/12/2010
Objection on applications	Note To Reviewer	SPI AssurantHealtha ndEmployeeBen f		0 02/10/2010

Company Tracking Number: IHAR01145FIF01

TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other

Product Name: Time Insurance-Base Chassis

Project Name/Number: Time Insurance-Base Chassis/IH AR01145FIF01

# **Disposition**

Disposition Date: 02/17/2010

Implementation Date: Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Company Tracking Number: IHAR01145FIF01

TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other

Product Name: Time Insurance-Base Chassis

Project Name/Number: Time Insurance-Base Chassis/IH AR01145FIF01

Schedule	Schedule Item	Schedule Item Status	<b>Public Access</b>
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document (revised)	Cover Letter	Approved-Closed	Yes
Supporting Document	Cover Letter	Replaced	Yes
Supporting Document	Statement of variability	Approved-Closed	Yes
Form (revised)	Application	Approved-Closed	Yes
Form	Application	Replaced	Yes
Form (revised)	Application	Approved-Closed	Yes
Form	Application	Replaced	Yes
Form (revised)	Application	Approved-Closed	Yes
Form	Application	Replaced	Yes
Form (revised)	Preferred Rating	Approved-Closed	Yes
Form	Preferred Rating	Replaced	Yes
Form (revised)	Amendment	Approved-Closed	Yes
Form	Amendment	Replaced	Yes

SERFF Tracking Number: ASWX-126478651 State: Arkansas
Filing Company: Time Insurance Company State Tracking Number: 44723

Company Tracking Number: IHAR01145FIF01

TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other

Product Name: Time Insurance-Base Chassis

Project Name/Number: Time Insurance-Base Chassis/IH AR01145FIF01

# **Objection Letter**

Objection Letter Status Pending Industry Response

Objection Letter Date 02/02/2010 Submitted Date 02/02/2010

Respond By Date

Dear Christine Fleming,

This will acknowledge receipt of the captioned filing.

## Objection 1

- Application, 29300 (Form)
- Application, 29400 (Form)
- Application, 29500 (Form)
- Preferred Rating, 26566 (Form)
- Amendment, 30216 (Form)
- Flesch Certification (Supporting Document)
- Application (Supporting Document)
- Cover Letter (Supporting Document)
- Statement of variability (Supporting Document)

#### Comment:

The name of the actual insurer/underwriter of the policy and forms must not be so small as to mislead the consumer on the true identity of the insurer. The name of the insurer needs to be in close conjunction and in the same size type as the letters, initials or symbols of Assurant Health.

Please feel free to contact me if you have questions.

Sincerely,

**Rosalind Minor** 

# **Response Letter**

Response Letter Status Submitted to State

Response Letter Date 02/17/2010 Submitted Date 02/17/2010

Dear Rosalind Minor,

SERFF Tracking Number: ASWX-126478651 State: Arkansas
Filing Company: Time Insurance Company State Tracking Number: 44723

Company Tracking Number: IHAR01145FIF01

TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other

Product Name: Time Insurance-Base Chassis

Project Name/Number: Time Insurance-Base Chassis/IH AR01145FIF01

**Comments:** Dear Ms. Minor,

# Response 1

Comments: Please see the attached revised cover letter and forms.

## **Related Objection 1**

## Applies To:

- Application, 29300 (Form)
- Application, 29400 (Form)
- Application, 29500 (Form)
- Preferred Rating, 26566 (Form)
- Amendment, 30216 (Form)
- Flesch Certification (Supporting Document)
- Application (Supporting Document)
- Cover Letter (Supporting Document)
- Statement of variability (Supporting Document)

#### Comment:

The name of the actual insurer/underwriter of the policy and forms must not be so small as to mislead the consumer on the true identity of the insurer. The name of the insurer needs to be in close conjunction and in the same size type as the letters, initials or symbols of Assurant Health.

#### **Changed Items:**

#### **Supporting Document Schedule Item Changes**

Satisfied -Name: Cover Letter

Comment:

#### Form Schedule Item Changes

Form Name	Form	Edition	Form Type	Action	Action	Readability	y Attach
	Number	Date			Specific	Score	Document
					Data		
Application	29300		Application/Enrollment	Initial		51.100	29300.PD
			Form				F
Previous Version							
Application	29300		Application/Enrollment	Initial		51.100	29300.PD

SERFF Tracking Number:	ASWX-126478651		State:		Arkansas		
Filing Company:	Time Insurance Company		State Tracking	g Number:	44723		
Company Tracking Number:	IHAR01145FIF01						
TOI:	H16G Group Health - Maj	or Medical	Sub-TOI:		H16G.001C Any	Size Group - O	ther
Product Name:	Time Insurance-Base Chas	sis					
Project Name/Number:	Time Insurance-Base Chas	sis/IH AR01145FIF	01				
		Form					F
Application	29400	Application/E	Enrollment	Initial		51.500	29400.PD
		Form					F
Previous Version							
Application	29400	Application/E	Enrollment	Initial		51.500	29400.PD
		Form					F
Application	29500	Application/E	Enrollment	Initial		52.300	29500.PD
		Form					F
Previous Version							
Application	29500	Application/E	Enrollment	Initial		52.300	29500.PD
		Form					F
Preferred Rating	26566	Other		Initial		54.900	26566.PD
							F
Previous Version							
Preferred Rating	26566	Other		Initial		54.900	26566.PD
							F
Amendment	30216	Certificate A	mendment,	Initial		53.800	30216.PD
		Insert Page,	Endorseme	nt			F
		or Rider					
Previous Version							
Amendment	30216	Certificate A	mendment,	Initial		53.800	30216.PD
		Insert Page,	Endorseme	nt			F
		or Rider					

No Rate/Rule Schedule items changed.

Sincerely,

Christine Fleming

Sincerely,

SPI AssurantHealthandEmployeeBenef

Company Tracking Number: IHAR01145FIF01

TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other

Product Name: Time Insurance-Base Chassis

Project Name/Number: Time Insurance-Base Chassis/IH AR01145FIF01

**Note To Filer** 

Created By:

Rosalind Minor on 02/12/2010 08:06 AM

Last Edited By:

**Rosalind Minor** 

**Submitted On:** 

02/17/2010 09:46 AM

Subject:

TIME LIMIT TO RESPOND

Comments:

Please respond by 3/2/10.

SERFF Tracking Number: ASWX-126478651 State: Arkansas
Filing Company: Time Insurance Company State Tracking Number: 44723

Company Tracking Number: IHAR01145FIF01

TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other

Product Name: Time Insurance-Base Chassis

Project Name/Number: Time Insurance-Base Chassis/IH AR01145FIF01

**Note To Reviewer** 

Created By:

SPI AssurantHealthandEmployeeBenef on 02/10/2010 08:11 PM

Last Edited By:

Rosalind Minor

**Submitted On:** 

02/17/2010 09:46 AM

Subject:

Objection on applications

Comments:

Dear Ms. Minor, I wanted to let you know that I am still waiting revisions on these forms from our product area, I hope to have them soon. Did you have a specific response date in mind?

Sincerely,

**Christine Fleming** 

Company Tracking Number: IHAR01145FIF01

TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other

Product Name: Time Insurance-Base Chassis

Project Name/Number: Time Insurance-Base Chassis/IH AR01145FIF01

## Form Schedule

Lead Form Number: 29300

_0aa : 0:::		-0000					
Schedule	Form	Form Type	Form Name	Action	Action Specific	Readability	Attachment
ltem	Number				Data		
Status							
Approved-	29300	Application	/Application	Initial		51.100	29300.PDF
Closed		Enrollment					
02/17/2010	)	Form					
Approved-	29400	Application	/Application	Initial		51.500	29400.PDF
Closed		Enrollment					
02/17/2010	)	Form					
Approved-	29500	Application	/Application	Initial		52.300	29500.PDF
Closed		Enrollment					
02/17/2010	)	Form					
Approved-	26566	Other	Preferred Rating	Initial		54.900	26566.PDF
Closed							
02/17/2010	)						
Approved-	30216	Certificate	Amendment	Initial		53.800	30216.PDF
Closed		Amendmer	า				
02/17/2010	)	t, Insert					
		Page,					
		Endorseme	Э				
		nt or Rider					

# Enrollment Form for Medical Insurance for Individuals and Families

AGENT/AGENC	Y INFORMAT	ION								
Agent Name:				Phon	e Nun	nber:				
Agent Number:				E-ma	il Adc	lress:				
Key Agency Conta	ct:			Agen	cy Na	me:				
Fax Number:				Agen	cy Nu	mber:				
TYPE OF ACTIV	/ITY (Please o	heck appropriat	e box.)							
□ NEW [If not a i	new enrollee, ci	neck appropriate	box and list o	affecte	d poli	cy number.				
☐ CHANGE/ADDIT	TON TO AN EXIS	TING POLICY. PO	LICY#							
☐ Internal Rep	lacement					☐ Remov	al/Redu	ction o	f Specia	al Class Premium
☐ Adding Depe								_	-	lent/divorce)
	Tobacco Rates  Preferred Rates					-		_		Existing Policy
1		ic Deductible or S	pecial Excep	tion Ri	der	☐ Reinsta		-		
DEDCOM/S) TO	DE INCHDED									
PERSON(S) TO	RE INSUKED									
	Last	Name First	М.І.	Sex	Age	Birthdate MM/DD/YY	State of Birth	Height	Weight	Social Security Number
1. PRIMARY										
2. SPOUSE [/DOMESTIC PARTNER] [/CIVIL UNION]										
3. DEPENDENT(S)	Last	<b>Name</b> First	М.І.	Sex	Age	Birthdate MM/DD/YY	Full-Time Student?	Height	Weight	Social Security Number
				-		1	1		1	
4a. Resident Addr	ess:									
		(Street)			(City)			(State	?)	(ZIP)
4b. E-mail Addres	ss:									
[5.] [Does any pro	posed insured	live outside the a	above housel	hold? .						. □ Yes □ No
If "Yes," expl	ain									
[6.] [Phone Numb									hat wo	ould be the best to
		inquire about me		_		•				

u.	Primary Insured Occ	upation:						
	Company Name:			Work N	Number: (	)		
	Duties:							
	•	d [self-employed] [or] [a		-				
	•	d covered by Workers' Co	•					
).		artner] [/Civil Union] Oc	•					
	Company Name:			Work N	lumber: (	)		
	• -	stic Partner] [/Civil Union				-		
	is the Spouse[/Dome	stic Partner] [/Civil Unio	nj coverea by	workers' Cor	npensation?		. ⊔ Yes	
	MPLETE IF REQUE	ESTING LIFE INSURAN	ICE COVERA	GE				
•	Beneficiary for Prima	ry Insured:	(Full N			(Relat	ionship)	
	Contingent Beneficia	ry:	,	,		,	,	
	-		(Full N	,		,	ionship)	
	The Primary Insured is th	he beneficiary of any Spouse [	/Domestic Partn	er] [/Civil Unic	on] or Child(ren) L	_ife Insurance.]]		
)	THER COVERAGE II	N FORCE OR APPLIED	FOR					
J		osed insureds covered by, rance?					□ Vos	
	[If "Yes," complete t		• • • • • • • • • • • • • • • • • • • •	•••••	••••••	•••••	🗆 ies	□ IV
	Proposed Insured's	Insurance Company	Group or	Type of	Effective Date	Termination	Is this co	verage
	Name	Name	Individual	Coverage	(MM/DD/YY)	Date	being repl	aced b
						(MM/DD/YY)	proposed o	overage
,	DAY				•			
J		nsureds covered under the ot covered					⊔ Yes	□ N
	נוו ווס, נושב נווסשב וונ	or covered.						
]		posed insureds ever been						
	•	excluded for life, disabilit s	•			•	' ⊔ Yes	
	[ii les, give details	·						
	ZADDOUG ACTIVIT	TIES AND DRIVING						
1/	AZAKDUUS ACIIVII							
1/	AZARDOUS ACTIVII							
	[Have any of the pro	posed insureds [ever] [in				_		
	[Have any of the propincluding but not lin	nited to, automobile, mo	torcycle or po	werboat raci	ing or any of th	e following	□Vos	
	[Have any of the propincluding but not lin activities: skydiving;	nited to, automobile, mo ; ultralight flying; scuba (	torcycle or po diving; hang gl	werboat raci	ing or any of the or mountain cli	ne following mbing?		
	[Have any of the propincluding but not lin activities: skydiving;	nited to, automobile, mo	torcycle or po diving; hang gl	werboat raci	ing or any of the or mountain cli	ne following mbing?	ued partic	
	[Have any of the propincluding but not lin activities: skydiving;	nited to, automobile, mo; ; ultralight flying; scuba o Who and Which Act	torcycle or po diving; hang gl	werboat raci	ing or any of th or mountain clii iten Do yo	ne following mbing?  Du plan contin	ued partic	
	[Have any of the propincluding but not lin activities: skydiving;	nited to, automobile, mo; ; ultralight flying; scuba o Who and Which Act	torcycle or po diving; hang gl ivity W	werboat raci	ing or any of th or mountain clii iten Do yo	ne following mbing?	ued partic	
.]	[Have any of the projincluding but not lin activities: skydiving:  [If "Yes," indicate:  ———————————————————————————————————	nited to, automobile, mo; ultralight flying; scuba o  Who and Which Act  posed insureds been cited	torcycle or po diving; hang gl ivity W	werboat raci	ing or any of th or mountain clii iten Do yo	ne following mbing?  ou plan contin     Yes   Yes	ued partic	
.]	[Have any of the propincluding but not line activities: skydiving: [If "Yes," indicate:	nited to, automobile, mo ; ultralight flying; scuba o Who and Which Act	torcycle or po diving; hang gl ivity W d for driving w [2] years?	werboat raci	ing or any of the property of	e following mbing?  ou plan contin  Yes  Yes  (5) years or	ued partic	□ No]

BILLING			
[ Monthly Check-O-Matic]	] Quarterly] [□ Semi-	Annual] [□ Annual] [□ List Bill	. (monthly only)]
[Credit Card:] [ First Payme	nt Only*] [ Monthly]	[□ Quarterly] [□ Semi-Ann	nual] [□ Annual]
[*With this option, you must select a sec necessary information.] If billing address is different than re		list bill for subsequent payments. Please ma	ke selection above and provide all
Payor Name	Address	City	State ZIP
AUTHORIZATION FOR CHECK-C	-MATIC BILLING ONLY	– Choose the following option that	applies:
$\square$ To begin Check-O-Matic with	drawals:		
Select a desired withdrawal de Bank Name:	· · · · · · · · · · · · · · · · · · ·	Jane Doe 1234 Any Street Anytown, US 12345	1234 DATE
City:	State:	DIV TO THE ODDED OF	PLE \$
$\square$ To add this policy to an exist	ng Check-O-Matic:	PAY TO THE ORDER OF	DOLLARS
Existing COM Number:	<del> </del>	ANYTOWN BANK	
Associated Policy Number:		MEMO	1234
		(ROUTING NUMBER - 9 DIGITS) (ACCOUNT NUMBER - 19 DIGITS)	BER) (CHECK NUMBER)
Routing Number:		Account Number:	
called DEPOSITORY, indicated on the	nce Company, hereinafter called other side, to debit the same to otification from me (or either of	d COMPANY, to initiate debit entries to the accoos such account. This authority is to remain in of us) of its termination in such time and in such	full force and effect until COMPANY and
Signature of Payor		Date Signed	
[AUTHORIZATION FOR CREDIT	CARD PAYMENTS		
When selecting MasterCard/VISA Ca I understand there will be no refund		alth to charge my account for the Individ y free look period in the contract.	ual Medical policy listed above.
□ VISA Card Number:			
☐ MasterCard Number:			
Exp. Date: /	Security Code Number (3	3 digits on back of credit card):	]
Name as it appears on card			
Signature of Payor:		Date:	]
HEALTH ADVOCATES ALLIA	NCE MEMBERSHIP A	PPLICATION	

Health Advocates Alliance is a membership organization that promotes good health among its members and their communities. Membership in the Alliance is required in order to be eligible for health insurance coverage. Membership privileges include the opportunity to participate in all programs offered or sponsored by the Association. For additional information and benefits provided by the Association please see the Health Advocates Alliance Brochure (Form JI-1033).

I hereby request enrollment in the Health Advocates Alliance. I understand that nominal dues are required for membership in the Association; if participating in a sponsored insurance program, then my annual dues may be collected in installments along with my insurance premiums. I also understand that membership dues are non-refundable, and my failure to remit membership dues will result in loss of eligibility to participate in any of the Association sponsored programs or benefits.

Member Signature Date

# **HEALTH STATEMENT**

IMPORTANT! PLEASE GIVE COMPLETE DETAILS OF EACH "YES" ANSWER ON THE "ADDITIONAL MEDICAL DETAILS" PAGE.

WITHIN THE LAST [10] YEARS HAS ANY PROPOSED INSURED:

WITHIN THE EAST [10] TEARS HAS ANT THE OSED INSORED.	
14.][HAD ANY DIAGNOSIS OF, RECEIVED TREATMENT FOR, OR CONSULTED WITH A PHYSICIAN	CONCERNING:
[a)] [The lungs or respiratory system including but not limited to: hayfever or other allergies sinus infections; asthma; bronchitis; tuberculosis; pneumonia or emphysema?	
[b)] [The heart or circulatory system including but not limited to: high blood pressure; hear heart murmur; chest pain; irregular heartbeat; varicose veins; phlebitis or elevated che	t attack;
[If "Yes," please provide last known blood pressure and cholesterol reading on the "Additional A	Nedical Details" page].]
[c)] [The digestive system including but not limited to: ulcer; gastritis; heartburn; intestinal colitis; gallbladder; hemorrhoids; hernia; disorder of the pancreas; spleen; or liver including not limited to; hepatitis; jaundice or cirrhosis?	uding but
[d)] [The nervous system including but not limited to: epilepsy; seizures; unconsciousness; vertigo; headaches; paralysis; multiple sclerosis; cerebral palsy; Parkinson's disease; st mini-stroke; TIA or brain attack?	convulsions; roke or
[e)] [Mental disease or nervous disorder including but not limited to: any emotional disorder depression; attention deficit disorder; eating disorder; or psychiatric treatment or could	- · · · · · · · · · · · · · · · · · · ·
[f)] [Congenital disorder, birth defects or developmental disorders including but not limited Down Syndrome; mental retardation; autism; cleft palate; club foot; or congenital hea	
[g)] [The genitourinary system including but not limited to: any kidney disorder; kidney sto prostatitis; bladder infections; or sexually transmitted disease?	
[h)] [Diabetes, high or low blood sugar or any disorder of the thyroid gland or other glandul	ar disorder? □ Yes □ No]
[i)] [The muscular, skeletal or connective tissue disorder including but not limited to: arthlupus (SLE); temporomandibular joint disease (TMJ); any back or spine disorder or trea any muscular or neuromuscular disorder or any manipulation therapy?	tment of
[j)] [Blood or lymph disorders including but not limited to anemia or lymphadenopathy?	_
[k)] [Cancer?	□ Yes □ No]
[l)] [Tumor, cyst or growth of any kind; any breast or skin disorders?	□ Yes □ No]
[m)][Any disorder of the eyes; ears (including ear infections or ear tubes); nose or throat.  Tonsils or adenoids; any speech or hearing impairment?	□ Yes □ No]
[n-1)][Any disorder of the reproductive organs, including but not limited to: disorders of the vagina; ovaries and cervix; uterus; diagnosed or treated for infertility or irregular men	
[n-2)] [To the best of your knowledge, are you, your spouse [/domestic partner] [/civil unio dependent now pregnant?	- ·
[n-3)] [Is any person not named on this enrollment form now pregnant by any person to be in	ısured? □ Yes □ No]
IF EITHER [N-2] OR [N-3] IS ANSWERED "YES," MEDICAL COVERAGE CANNOT BE ISSUED.	
QUESTIONS N-4 – N-6 FOR FEMALE APPLICANTS:	
[n-4)][Complications of pregnancy, including but not limited to caesarean section delivery or miscarriage?	- 1
[n-5)][Date of Last Pap Smear: Results:	<u>- 1</u>
[n-6)][Have you been instructed to have a repeat Pap Smear or any follow-up treatment or t result of your last Pap Smear?	
15.] [Been diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS	•
member of the medical profession?	r of
the medical profession?	-
lymphadenopathy (swollen lymph nodes); loss of appetite; weight loss; chronic fatigue; fev	er;
oral thrush; skin rashes; unexplained infections; dementia; depression; or other psychoneur	
disorders with no known cause?	
has not been completed?	

[10 ] [Doos any porson have	
	any fixation/prosthetic devices present including but not limited to: plates; (including breast implants); shunts; pacemakers or valve replacements? $\square$ Yes $\square$ No]
	ram, chest x-ray, or blood test or any other diagnostic testing of any kind or lin the past [10] years?
[If "Yes," give name of	physician or hospital and results on the "Additional Medical Details" page].]
counseling for alcoholi	coholics Anonymous or had any treatment, including but not limited to, sm or alcohol abuse or been advised by a physician to discontinue or decrease
	uilizers; cocaine or other hallucinogenic or narcotic drugs; or received treatment nical dependency?
ADDITIONAL QUESTIONS	
	nowledge, does any person to be insured have any mental or physical impairment, ot indicated above?
	use [/domestic partner] [/civil union] (if to be insured) smoked cigarettes or
	orm or nicotine substitute within the past year? PRIMARY INSURED
	PARTNER] [/CIVIL UNION] (if to be insured)
, , .	use [/domestic partner] [/civil union] EVER smoked cigarettes or used
•	o, amount per day and year quit on the "Additional Medical Details" page].]
- · · · · · · · · · · · · · · · · · · ·	ed currently taking, or taken within the past [12] months, any prescription
medication, or receivi	ng medical treatment of any kind [or is currently taking, or taken, any non on a daily basis]?
[If "Yes," provide deta "Additional Medical De	ails of treatment including name and dosage of all medications on the etails" page1.1
	1,43-14
REOUESTING THE REMOVAL	OF A SPECIAL CLASS PREMIUM, SPECIAL EXCEPTION RIDER OR CONDITION SPECIFIC DEDUCTIBLE
physician concerning t	nedical treatment or medication use for, or have you consulted with a the condition(s) which has had a Condition Specific Deductible, been ridered
physician concerning t or rated since the cove	the condition(s) which has had a Condition Specific Deductible, been ridered ered person's effective date?
physician concerning t or rated since the cove	he condition(s) which has had a Condition Specific Deductible, been ridered
physician concerning to or rated since the cover [If "Yes," provide deta	the condition(s) which has had a Condition Specific Deductible, been ridered ered person's effective date?
physician concerning to or rated since the cove [If "Yes," provide deta	the condition(s) which has had a Condition Specific Deductible, been ridered ered person's effective date?
physician concerning to or rated since the cove [If "Yes," provide deta	the condition(s) which has had a Condition Specific Deductible, been ridered ered person's effective date?
physician concerning to or rated since the cove [If "Yes," provide deta  OTHER PHYSICIANS  [27.] [Regular physician or no reason and results.	the condition(s) which has had a Condition Specific Deductible, been ridered ered person's effective date?
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physician concerning to or rated since the cove [If "Yes," provide deta  OTHER PHYSICIANS  [27.] [Regular physician or not reason and results.  Primary Proposed Inst. Address Date Last Seen Spouse's [/Domestic Paddress	the condition(s) which has had a Condition Specific Deductible, been ridered ered person's effective date?
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physician concerning to or rated since the cove [If "Yes," provide deta  OTHER PHYSICIANS  [27.] [Regular physician or many proposed Instruction Address	the condition(s) which has had a Condition Specific Deductible, been ridered ered person's effective date?
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physician concerning to or rated since the cove [If "Yes," provide deta  OTHER PHYSICIANS  [27.] [Regular physician or many proposed Instruction Address	the condition(s) which has had a Condition Specific Deductible, been ridered ered person's effective date?

# ADDITIONAL MEDICAL DETAILS

Attach a separate sheet if additional space is needed. Date and sign any additional sheets.

	Provide Dates, Type of Treatment and Results	Name of Doctor/Hospital and Complete Address and Phone Number
Person:		
Condition:		
Question #:		
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Condition:		
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## **EMPLOYER SPONSORED BUSINESS (ESB) STATEMENT**

You understand and agree that you are applying for individual health insurance for you (and your family). You further understand that this application
for health insurance will be fully medically underwritten and that coverage is not guaranteed. You are personally paying the entire premium for thi
health insurance coverage. Your employer is not contributing in any way to the payment of premium, either directly or indirectly.

Do you agree with this statement? $\Box$	Yes	□ No]
--	-----	-------

## **AUTHORIZATION**

[I represent to the best of my knowledge and belief, that all statements and answers on this enrollment form are complete and true. The enrollment form and any amendments shall be the basis for the contract. I also agree that:

Except as otherwise provided in the Conditional Receipt, the insurance, if approved by Time Insurance Company, will be in force only when issued by Time Insurance Company. The first full premium must be paid. Coverage will become effective on the later of: A) The date we receive the enrollment form; B) the requested Effective Date. A change in the health of the proposed insured(s) after the completion of the enrollment form and before the delivery of the contract may affect my eligibility for insurance with the company. The contract may only be effective prior to the contract delivery subject to the terms of the Conditional Receipt.]

[I agree that a photographic copy of this authorization shall be valid for two years from the date signed.]

[I acknowledge receiving the notification regarding [MIB, Inc.,] the Abbreviated Notice of Insurance Information Practices and the Outline of Coverage for Health Insurance, if required.]

[We, the undersigned Proposed Insured(s) and agent, acknowledge that the Proposed Insured(s) has read the completed enrollment form. We understand and acknowledge that any fraudulent statement or material misrepresentation or omission on the enrollment form and/or any amendments may result in claim denial or contract rescission, subject to the time limit on certain defenses or incontestability provisions of the contract.]

[I hereby authorize any health care provider or medically related facility, pharmacy or pharmacy related facility, [MIB Inc.], consumer reporting agency, insurance or reinsurance company or employer having information about me or my minor children to provide all such information as may be requested to Time Insurance Company, its legal representative or any medical records retrieval service Time Insurance Company may engage, including, but not limited to, [EMSI] and its agents.]

[This authorization includes any and all information you may have about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, prescription history, lab data and EKGs. This information may also be disclosed to [MIB, Inc.] and any medical records company engaged by Time Insurance Company, including but not limited to [EMSI] and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Time Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. A copy of this authorization will be valid as an original.]

[I understand that this authorization is required in order to enable Time Insurance Company to make eligibility or enrollment determinations relating to me and/or my minor children or for Time Insurance Company's underwriting or risk rating determinations. If I refuse to sign or revoke this authorization, Time Insurance Company may refuse to consider my application for enrollment.]

[I understand that I may revoke this authorization at any time by notifying Time Insurance Company in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, Time Insurance Company, P.O. Box 3050, 501 West Michigan, Milwaukee, WI 53201-3050. Such revocation will not be valid if Time Insurance Company has taken action in reliance on the authorization.]

[Unless an earlier date is required by law, this authorization expires upon the earliest of the following events: [30] days after denial of my application, or declination of enrollment, or, if insured, [30] days after when I am no longer an insured of Time Insurance Company. But in no event will this authorization be in effect for longer than [24] months from the date signed.]

		A.M. / P.M.			
Signature of Primary Proposed Insured	Date Signed	Time Signed	City	State	
Signature of Spouse[/Domestic Partner] [/Civil Union] or Other (if proposed to be insured)	Attention: (Agent) I have reviewed the items have been of	nis enrollment form to	ensure that all re	quired	
		wledge, there 🗆 <b>IS</b> [nce involved in this tra		ement	
Signature(s) of Other Dependent(s) 18 or Over (if proposed to be insured)	Are you aware of any mental or physical impairment, disease, or deformity of any proposed insured which is not disclosed on the enrollment form?   Yes  No				
Guardian's Signature	If "Yes," please explain				
Requested Effective Date:	_				
Premium Amount Sent: \$	Licensed Resident Agent's Signature  Print Agent's Name				
One-time Processing Fee Sent*:					
Conditional Receipt Taken: 🗆 Yes 🗆 No	Initial here if you witnessed the signing of this form by the proposed insured.				

## ADDITIONAL NOTICES

#### [NOTIFICATION REGARDING [MIB, Inc.] [("MIB")] [formerly known as the Medical Information Bureau]

Information regarding your insurability will be treated as confidential. Time Insurance Company or its reinsurers may, however, make a brief report thereon to [the] [MIB, Inc.,] [formerly known as Medical Information Bureau], a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another [MIB] member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, [MIB,] upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, [MIB] will arrange disclosure of any information in your file. Please contact [MIB] at [866 692-6901] [(TTY 866 346-3642)]. If you question the accuracy of information in [MIB's] file, you may contact [MIB] and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of [MIB's] information office is [50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734].

Time Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life, or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about [MIB] may be obtained on its website at [www.mib.com].]

#### ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

To issue an insurance policy or certificate, we need to obtain information about you and any other person proposed for insurance. Some of that information will be received from you, and some will be generated from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact Time Insurance Company, Underwriting Department, 501 West Michigan, Milwaukee, Wisconsin, 53203.

#### FRAUD NOTICE

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Division of Insurance within the Department of Regulatory Agencies.

#### **PRIVACY**

We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted by law. We collect non-public information about you from the following sources: (1) information we receive from you on enrollment forms or other information related thereto or as part of policy administration, and (2) information about your transactions with our affiliates, others or us. We restrict access to non-public personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your non-public personal information. We may disclose non-public personal information about you to nonaffiliated third parties as permitted by law.]

## **CONDITIONAL RECEIPT**

This Conditional Receipt is received from	, this day of
(month) (year).	

If full premium is paid and Time Insurance Company accepts this application as applied for within (30) days of the date the application is signed, the effective date will be as specified above, but I agree that I have no insurance coverage under this application until Time Insurance Company notifies me in writing that my application is approved. No agent or broker of the Company is authorized to alter or waive the conditions of this conditional receipt.

For coverage to become effective, each individual to be covered must be a risk acceptable to Time Insurance Company as applied for and at a standard or preferred rate with no Special Exception Riders on the later of: the Requested Effective Date or the Date on which Time Insurance Company receives the application at its home office.

I understand that Time Insurance Company has the right to deny my application and if it does so I will be notified in writing and the premium I submitted will be returned.

If I do not select an effective date, Time Insurance Company will assign an effective date that is later than the date the application is approved.

I must advise Time Insurance Company of any change in information included in the application for me or any person to be insured that occurs after the date I sign the application until the later of the effective date of coverage or the date Time Insurance Company receives the application at its home office. Failure to update Time Insurance Company regarding these changes may result in coverage being voided.]

# Tele-App Part 1 Enrollment Form for Medical Insurance for Individuals and Families

PLEASE PRINT IN BLACK INK

										_
AGENT/AGENCY	INFO	RMATION								
Agent Name:				Phone N	lumbe	r:				
Agent Number:				E-mail A	Addres	s:				
Key Agency Contact	::			Agency	Name:	i				
Fax Number:				Agency	Numbe	er:				
TYPE OF ACTIVI	TV (D	lease check appropriate	hov.)							
		llee, check appropriate b	•	facted n	olicy r	umbar				
		N EXISTING POLICY. POL								
									1 (/1)	
☐ Internal Repla	cement				Ц	Conversion	(over age	aepen	ident/divorce)	
PERSON(S) TO B	E INSU	JRED								
		Name		Sex	Age	Birthdate	State	Soci	ial Security Number	
4. DDIMADV	Last	First	MI			(MM/DD/YY)	of Birth			
1. PRIMARY  2. SPOUSE[/										
DOMESTIC PARTNER] [/CIVIL UNION]										
3. DEPENDENT(S) (list relationship)	Last	<b>Name</b> First	MI	Sex	Age	Birthdate (MM/DD/YY)	Full-time Student?	Soci	al Security Number	
4. Resident Address	s:			(Cit. 1)			(54-4-)		(7/0)	
(NO P.O. BOXES)	,	(Street)	,	(City)			(State)		(ZIP)	
[5.] [Phone Number:	,	) I insureds covered by an		o. E-ma						_]
		·····								
Proposed Insured' Name	S	Insurance Company Name	Group or Individual	Type Cove		Effective Date (MM/DD/YY)	Terminat Date		Is this coverage being replaced by proposed coverage?	
							(אואי)	'''	highosed coverage:	
			1							

7b.	Primary Insured Occupation:				
	Company Name:		)		
	Duties:				
	Is the Primary insured [self-employed] [or] [a sole plane in the Primary Insured covered by Workers' Compensation				□ No □ No
7c.	Spouse [/Domestic Partner] [/Civil Union] Occupati	ion:			
	Company Name:				
	Duties:				
	Is the Spouse[/ Domestic Partner] [/Civil Union] [se Is the Spouse[/ Domestic Partner] [/Civil Union] co	. ,	• • •		□ No □ No
BIL	LLING				
[□ <i>N</i>	Nonthly Check-O-Matic] $[\Box$ Quarterly] $[\Box$ Semi-	Annual] [🗆 Annual]	[□ List Bill (monthly only	<i>(</i> )]	
[Cred	dit Card:] [□ First Payment Only*] [□ Monthly]	[ $\square$ Quarterly] [[	☐ Semi-Annual] [☐	Annual]	
	this option, you must select a secondary billing mode other than nation.]	list bil for subsequent paymer	nts. Please make selection ab	ove and prov	ide all neces.
If billi	ing address is different than resident address, please comp	olete:			
Payor	Name Address	Cit	y St	ate	ZIP
AUTI	HORIZATION FOR CHECK-O-MATIC BILLING ONLY	- Choose the following	option that applies:		
	begin Check-O-Matic withdrawals:	,	тр		
	elect a desired withdrawal day (1–28):	Jane Doe			1234
	ank Name:	1234 Any Street Anytown, US 12345	DATE		
	ty: State:	l	AMPLE	\$	II
□То	add this policy to an existing Check-O-Matic:	PAY TO THE ORDER OF	EXAM	D	OLLARS
Ex	cisting COM Number:	ANYTOWN BANK			
As	ssociated Policy Number:	MEMO	0987654321		1234
	,	(ROUTING NUMBER - 9 DIGITS)	(ACCOUNT NUMBER)	(CI	HECK NUMBER)
Pour	ting Number:	Agg	west Numbers		
		, ACC	ount Number:		
l (1 ca DE	heck-O-Matic (Complete authorization below) we) hereby authorize Time Insurance Company, hereinafter called of the DEPOSITORY, indicated on the other side, to debit the same to EPOSITORY have received written notification from me (or either of EPOSITORY a reasonable opportunity to act on it.	such account. This authority i	s to remain in full force and e	ffect until CO	OMPANY and
Signat	cure of Payor	Date Signed			
ΓΔΙΙΤ	THORIZATION FOR CREDIT CARD PAYMENTS				
When	n selecting MasterCard/VISA Card: I authorize Assurant Hea erstand there will be no refund of premium after the 10-da			olicy listed	above.
□ V	ISA Card Number:				
	lasterCard Number:				
	xp. Date: / [Security Code Number (3				
	Name as it appears on card:				
	Signature of Payor:	Date:		7	l
		Dutc.		J	1

Beneficiary for Primary Insured:			
, , ,	(Full Name)	(Relationship)	
Contingent Beneficiary:			
	(Full Name)	(Relationship)	
The Primary Insured is the beneficiary of any Spouse [/	/Domestic Partner] [/Civil Union] or Child(ren	n) Life Insurance.]	
HEALTH ADVOCATES ALLIANCE MEMBE	RSHIP APPLICATION		
Health Advocates Alliance is a membership organ Membership in the Alliance is required in order to the opportunity to participate in all programs off provided by the Association please see the Healtl	o be eligible for health insurance coverage fered or sponsored by the Association. Fo	ge. Membership privileges include or additional information and benefits	
I hereby request enrollment in the Health Advocates Alliance. I understand that nominal dues are required for membership in the Association; if participating in a sponsored insurance program, then my annual dues may be collected in installments along with my insurance premiums. I also understand that membership dues are non-refundable, and my failure to remit membership dues will result in loss of eligibility to participate in any of the Association sponsored programs or benefits.			

COMPLETE IF REQUESTING LIFE INSURANCE COVERAGE

Date

Member Signature

EMPLOYER SPONSORED BUSINESS (ESB) STATEM	MENT
understand that this application for health insurance v	ividual health insurance for you (and your family). You further will be fully medically underwritten and that coverage is not ium for this health Insurance coverage. Your employer is not ither directly or indirectly.
Do you agree with this statement?	
AUTHORIZATION	
hospital, clinic, any pharmacy, pharmacy benefit manage insurance company, [MIB, Inc.,] employer, or consumer consumer-reporting agency authorized by Time Insurance	e, I authorize any licensed physician, medical practitioner, er or pharmacy-related entity, any medically-related facility, r-reporting agency to give Time Insurance Company (or any e Company) any information regarding me or my family as to nation, and medical or pharmacy care, advice or treatment,
true. My recorded Personal Health History, Part 1 and a agree that: (1) Within 30 days of policy delivery, I must enrollment form information with a signature and retu (2) Except as otherwise provided in the Conditional Rece will be in force only when issued by Time Insurance Con any information I provide through this application proces coverage, including but not limited to my agent or broke	nat all statements and answers on Part 1 are complete and any amendments shall be the basis for the contract. I also to formally accept the offer by verifying the accuracy of the arning that signed acceptance to Time Insurance Company, eipt, the insurance, if approved by Time Insurance Company, mpany and accepted by me. (3) I understand and agree that ss may be shared with persons necessary to facilitate issuing er. (4) If any of these conditions are not met, Time Insurance and the full extent of its liability shall be limited to the sum
[MIB, Inc.,] consumer reporting agency, insurance or reme or my minor children to provide all such information	ally related facility, pharmacy or pharmacy related facility, einsurance company or employer having information about n as may be requested to Time Insurance Company, its legal e Time Insurance Company may engage, including, but not
regarding diagnosis, testing, treatment and prognosis o treatment, drug abuse treatment, psychiatric treatment testing and treatment, sickle cell testing and treatment may also be disclosed to [MIB, Inc.] and any medical receive but not limited to [EMSI] and its agents. Although federal information disclosed pursuant to this authorization made protected by such regulation, all information receive	nay have about me, including, but not limited to, information of my physical or mental condition as well as alcohol abuse of, pharmacy prescriptions, HIV testing and treatment, STD to, prescription history, lab data and EKGs. This information ords company engaged by Time Insurance Company, including a regulations require that we inform you of the potential that by be subject to redisclosure by the recipient and no longer d by Time Insurance Company pursuant to this authorization regulations. A copy of this authorization will be valid as an
enrollment determinations relating to me and/or my m	er to enable Time Insurance Company to make eligibility or inor children or for Time Insurance Company's underwriting e this authorization, Time Insurance Company may refuse to
my desire to revoke. Such revocation must be sent by o	ny time by notifying Time Insurance Company in writing of certified mail to the following address: Privacy Office, Time Wilwaukee, WI 53201-3050. Such revocation will not be valid on the authorization.]
[30] days after denial of my application, or declination	rization expires upon the earliest of the following events: of enrollment, or, if insured, [30] days after when I am no event will this authorization be in effect for longer than [24]
Signature of Primary Proposed Insured (Circle one)	Signature of Spouse or Other Insured (if proposed to be insured)
A.M. / D.M.	

[REMEMBER TO FAX PAGES 1, 2, 3 & 4 AND THE SOFTWARE PROPOSAL TO [414-299-6020]]

City & State

Requested Policy Effective Date

Date Signed

Conditional Receipt Given?

Time Signed

☐ Yes

#### **ADDITIONAL NOTICES**

#### [NOTIFICATION REGARDING [MIB, Inc.] [("MIB")] [formerly known as the Medical Information Bureau]

Information regarding your insurability will be treated as confidential. Time Insurance Company or its reinsurers may, however, make a brief report thereon to [the] [MIB, Inc.,] [formerly known as Medical Information Bureau], a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another [MIB] member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, [MIB,] upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, [MIB] will arrange disclosure of any information in your file. Please contact [MIB] at [866 692-6901] [(TTY 866 346-3642)]. If you question the accuracy of information in [MIB's] file, you may contact [MIB] and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of [MIB's] information office is [50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734].

Time Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life, or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about [MIB] may be obtained on its website at [www.mib.com].]

#### ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

To issue an insurance policy or certificate, we need to obtain information about you and any other person proposed for insurance. Some of that information will be received from you, and some will be generated from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact Time Insurance Company, Underwriting Department, 501 West Michigan, Milwaukee, Wisconsin, 53203.

#### **FRAUD NOTICE**

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Division of Insurance within the Department of Regulatory Agencies.

## **PRIVACY**

We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted by law. We collect non-public information about you from the following sources: (1) information we receive from you on enrollment forms or other information related thereto or as part of policy administration, and (2) information about your transactions with our affiliates, others or us. We restrict access to non-public personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your non-public personal information. We may disclose non-public personal information about you to nonaffiliated third parties as permitted by law.

## **CONDITIONAL RECEIPT**

This Conditional Receipt is received from	, this	_ day of	(month)
(year).			
If full premium is paid and Time Insurance Company accepts this application as ap	plied for within (	(30) davs of the date th	e

If full premium is paid and Time Insurance Company accepts this application as applied for within (30) days of the date the application is signed, the effective date will be as specified above, but I agree that I have no insurance coverage under this application until Time Insurance Company notifies me in writing that my application is approved. No agent or broker of the Company is authorized to alter or waive the conditions of this conditional receipt.

For coverage to become effective, each individual to be covered must be a risk acceptable to Time Insurance Company as applied for and at a standard or preferred rate with no Special Exception Riders on the later of: the Requested Effective Date or the Date on which the Personal Health History call is completed.

I understand that Time Insurance Company has the right to deny my application and if it does so I will be notified in writing and the premium I submitted will be returned. If I do not select an effective date, Time Insurance Company will assign an effective date that is later than the date the application is approved.

I must advise Time Insurance Company of any change in information included in the application for me or any person to be insured that occurs after the date I sign the application until the later of the effective date of coverage or the date on which the Personal Health History call is completed. Failure to update Time Insurance Company regarding these changes may result in coverage being voided.

Policy #:	
•	

# **Acceptance of Offer and Attestation**

I represent to the best of my knowledge and belief, that all statements and answers on this enrollment form are complete and true. My recorded Personal Health History, the enrollment form and any amendments shall be the basis for the offer of coverage. I also agree that:

Except as otherwise provided in the Conditional Receipt, the insurance, if approved by Time Insurance Company, will be in force only when issued by Time Insurance Company. I shall sign the enrollment form and obtain the signatures of my Spouse [Domestic Partner] [Civil Union] and any covered dependents over the age of 18, and return it to Time Insurance Company within 30 days of the contract issue. If acceptance is not received within 30 days, Time Insurance Company reserves the right to revoke any and all such offers. The first full premium must be paid. The contract may only be effective prior to the contract delivery and acceptance, if all the terms of the Conditional Receipt have been fulfilled.

I agree that a photocopy of this authorization shall be valid for two years from the date signed. I acknowledge receiving the Fair Credit Reporting Act Pre-Notification, the notification regarding the Medical Information Bureau, the Privacy statement concerning my personal health information, the Abbreviated Notice of Insurance Information Practices, and the Outline of Coverage for Health Insurance, if required.

We, the undersigned proposed insured(s) and agent acknowledge that the proposed insured(s) has read the completed enrollment form. We understand and acknowledge that any fraudulent statement or material misrepresentation on the enrollment form and/or any amendments may result in claim denial or contract rescission, subject to the time limit on certain defenses or incontestability provisions of the contract.

Signature of Proposed Insured		
Date Signed	State	[If Life Insurance is issued, complete this section.  Beneficiary for Primary Insured:
Signature of Spouse or Other Insu	ured	Full Name and Relationship
Signature(s) of Other Dependents 18 or Over		Contingent Beneficiary:
Guardian's Signature		Full Name and Relationship
		(The Primary Insured is the Beneficiary of any spouse [/domestic partner]

# Enrollment Form for Medical Insurance for Individuals and Families

AGENT/AGENCY	INFORMATI	ON								
Agent Name:				Phone	Numb	er:				
Agent Number:				E-mail	Addre	ess:				
Key Agency Contact:				Agency	/ Nam	e:				
Fax Number:			<u>-</u>	Agency	/ Num	ber:				<u>-</u>
TYPE OF ACTIVIT	TY (Please c	heck appropriat	e box.)							
□ <b>NEW</b> If not a new	enrollee, che	ck appropriate b	ox and list af	fected <sub>l</sub>	oolicy	number.				
☐ CHANGE/ADDITIO	N TO AN EXIST	TING POLICY. PO	LICY #							
☐ Internal Replac	ement				[	☐ Convers	ion (over	age d	epende	nt/divorce)
L										
PERSON(S) TO BI	E INSURED									
		Name		Sex	Age	Birthdate	State	Height	Weight	Social Security Numbe
	Last	First	М.І.		7.50	MM/DD/YY	of Birth	. icigiic	,,c.g.ic	Social Security Hamse
1. PRIMARY										
2. SPOUSE [/DOMESTIC PARTNER]										
[/CIVIL UNION]										
3. DEPENDENT(S)	Last	Name First	М.І.	Sex	Age	Birthdate MM/DD/YY	Full-Time Student?	Height	Weight	Social Security Number
	Lust	LIISL	M.I.			MM/DD/TT	Studenti			
							•			
4a. Resident Addre	ess:	(Street)			(6:1)			(5)		(7/0)
		, ,			(City)			(State	?)	(ZIP)
4b. E-mail Address	:									
[5.] [Does any prop	oosed insured	live outside the	above house	ehold? .						. □ Yes □ No
If "Yes," expla	in									
[6.] [Phone Numbe	r: (	)		[	Please	e list the p	hone nu	mber t	hat wo	ould be the best to

Duties Is the Is the Proposed	es:e Primary Insure e Primary Insure e Primary Insure se[/Domestic Foany Name:es:e Spouse[/Domestic Foany Name]  COVERAGE IN	ed [self-employed] [or] [and covered by Workers' Covered by Workers' Covered by Workers' Covered by Partner] [/Civil Unicoversic Par	a sole proprieto ompensation?. ccupation: on] [self-emploon] covered by  FOR  y, or has applic	or]?  Work  yed] [or] [a  Workers' Co	Number: (sole proprietor]	)		N
Is the Is the Is the Comp Duties Is the Is t	e Primary Insure e Primary Insure e Primary Insure e Se[/Domestic Foany Name: es: e Spouse[/Dome e Spouse[/Dome e Spouse]  COVERAGE IN any of the prop of medical insu	ed [self-employed] [or] [and covered by Workers' Covered by Italian Covered Covered by Italian Covered	a sole proprieto ompensation?. ccupation: on] [self-emploon] covered by  FOR  y, or has applic	or]?	Number: (sole proprietor	)	□ Yes	□ N
Is the  Zb.] Spous Comp Duties Is the Is the  Solution Is the Is the Is the	e Primary Insure se[/Domestic F pany Name: es: e Spouse[/Dome e Spouse[/Dome c Spouse]  COVERAGE IN any of the prop of medical insu	ed covered by Workers' Covered by Workers' Covered by Workers' Covered by Partner] [/Civil Unicoversic	ompensation?ccupation: on] [self-emploon] covered by  FOR  y, or has applic	Work work workers? Co	Number: (sole proprietor]	)	□ Yes	
OTHER COMPANDED IS the	se[/Domestic Foany Name:es:e Spouse[/Domestic Foany Name:es:e Spouse[/Domestic Foany of the propof medical insurance foany of the proposition foany of the propo	Partner] [/Civil Union] O  Pestic Partner] [/Civil Unice  Pest	pn] [self-emploon] covered by  FOR  y, or has applic	Work   nyed] [or] [a Workers' Co	Number: (sole proprietor]	]?	□ Yes	
Comp Duties Is the Is the  OTHER C  8.] [Are a type c [If "Ye  Proposed	coany Name:es:e Spouse[/Domese Spouse]  COVERAGE IN any of the propof medical insu	estic Partner] [/Civil Unic estic Partner] [/Civil Unic N FORCE OR APPLIED osed insureds covered by rance?	on] [self-emploon] covered by  FOR  y, or has applic	Work   nyed] [or] [a Workers' Co	Number: (sole proprietor	]?	□ Yes	
Duties Is the Is the  OTHER O  (8.] [Are a type o [If "Ye	es:e Spouse[/Dome e Spouse[/Dome cOVERAGE IN any of the prop of medical insu	estic Partner] [/Civil Unicestic Partner] [/Civi	on] [self-emploon] covered by  FOR  y, or has applic	yed] [or] [a Workers' Co	sole proprietor	]?	🗆 Yes	
OTHER COST IS THE	e Spouse[/Dome e Spouse[/Dome  COVERAGE IN  any of the prop of medical insu	estic Partner] [/Civil Unic estic Partner] [/Civil Unic N FORCE OR APPLIED osed insureds covered by rance?	on] [self-emploon] covered by  FOR  y, or has applic	yed] [or] [a Workers' Co	sole proprietor	_		
OTHER COMES	COVERAGE IN any of the propof medical insu	FORCE OR APPLIED osed insureds covered by	FOR  y, or has applic	Workers' Co	mpensation?	_		
OTHER C  8.] [Are a type c [If "Ye Proposec	COVERAGE IN any of the prop of medical insu	S FORCE OR APPLIED osed insureds covered by rance?	<b>FOR</b> y, or has applic				□ Yes	□ N
8.] [Are a type of [If "Ye	any of the prop of medical insu	osed insureds covered by	y, or has applic	ation been r				
type of [If "Ye	of medical insu	rance?		ation been r				
type of [If "Ye	of medical insu	rance?			nade for any			
Proposed	es," complete				-		. □ Yes	□1
		the section below.						
	ed Insured's lame	Insurance Company Name	Group or Individual	Type of Coverage	Effective Date (MM/DD/YY)	Termination Date	Is this cov	
					, ,	(MM/DD/YY)	proposed co	overage
							+	
9.] [Were	e all proposed i	nsureds covered under tl	he prior plan li	sted above?		. <b></b>	□ Yes	□ 1
		posed insureds within the				, rescinded, re	eformed, ch	arged
		r had a portion of covera					□ Yes	□ 1
		<b>5.</b>						
11 10	ss, give details	··						

BILLING			
[□ Monthly Check-O-Matic] [□ Quarterly] [□ Semi-A	Annual] [□ Annual] [[	List Bill (monthly only)	I
[Credit Card:] [☐ First Payment Only*] [☐ Monthly]	[ $\square$ Quarterly] [ $\square$	Semi-Annual] [	Annual]
[*With this option, you must select a secondary billing mode other than sary information.]	list bill for subsequent payment	s. Please make selection abo	ve and provide all neces
If billing address is different than resident address, please comp	lete:		
Payor Name Address	City	Stat	te ZIP
AUTHORIZATION FOR CHECK-O-MATIC BILLING ONLY	- Choose the following o	ption that applies:	
☐ To begin Check-O-Matic withdrawals:	, ,		
Select a desired withdrawal day (1-28): Bank Name:	Jane Doe 1234 Any Street Anytown, US 12345		1234
City:State:		ANDLE	
☐ To add this policy to an existing Check-O-Matic:	PAY TO THE ORDER OF	XAM.	DOLLARS
Existing COM Number:	ANYTOWN BANK		DOLLARS
Associated Policy Number:	MEMO	0987654321	1234
	(ROUTING NUMBER - 9 DIGITS)	(ACCOUNT NUMBER)	(CHECK NUMBER)
Routing Number:	Accou	nt Number:	
Charle O Matic (Camples authorization below)			
Check-O-Matic (Complete authorization below)  I (we) hereby authorize Time Insurance Company, hereinafter called C called DEPOSITORY, indicated on the other side, to debit the same to DEPOSITORY have received written notification from me (or either of DEPOSITORY a reasonable opportunity to act on it.	such account. This authority is t	o remain in full force and effo	ect until COMPANY and
Signature of Payor	Date Signed		
[AUTHORIZATION FOR CREDIT CARD PAYMENTS  When selecting MasterCard/VISA Card: I authorize Assurant Heal I understand there will be no refund of premium after the 10-day	free look period in the cont	ract.	icy listed above.
□ VISA Card Number:			
Exp. Date: / [Security Code Number (3			
[233.13]	2 J 22 211 2 231 0 0 0 0 0 0 0 0		
Name as it appears on card:			
Signature of Payor:	Data		1

# **HEALTH STATEMENT**

# For Questions [13]-[25,] WITHIN THE LAST [10] YEARS, HAS ANY PROPOSED INSURED:

[Note	e: any follow-up visits in the last [10] years as a result of a diagnosis over [10] years ago must be discl	osed.]	
[13.]	[Had surgery [in a hospital or outpatient facility]?	$\square$ Yes	□ No]
[14.]	[Had medical treatment [in a hospital or outpatient facility]?	☐ Yes	□ No]
[15.]	[Had any urgent care or emergency room visits]?	$\square$ Yes	□ No]
[16.]	[Received treatment, testing, consulted with or received a diagnosis from a physician or healthcare provider? Do NOT include annual physical exams]	□ Yes	□ No]
[17.]	[Had any testing with [abnormal findings] or tests for which you have not received results?	☐ Yes	□ No]
[18.]	[Been recommended or scheduled for diagnostic testing, consultations, treatment, follow-up or surgery that has not been completed?	□ Yes	□ No]
[19.]	[Received or recommended to have any treatment for alcoholism, alcohol or drug abuse or addiction, including but not limited to, counseling or attendance at support groups?	□ Yes	□ No]
[20.]	[Used illegal drugs or prescription medication other than as prescribed or been advised by a physician or health care provider to discontinue or decrease alcohol consumption or drug use?	□ Yes	□ No]
Addi	tional Questions		
[21.]	[Has any proposed insured taken or been advised to take any prescription medication in the last [[10] years] [[12] months]?	□ Yes	□ No]
[22.]	[Has any proposed adult [ever] used tobacco products in any form or nicotine substitutes within the last [10] years]?	□ Yes	□ No]
[23.]	[Has any proposed insured had a diagnosis, treatment or follow-up for cancer in the last [10] years?	□ Yes	□ No]
[24.]	[Is any proposed insured currently pregnant, an expectant parent or in the process of adoption or surrogate pregnancy?	□ Yes	□ No]
[25.]	[Have you fully disclosed all medical conditions for you and your family within the last [10] years? $\dots$	□ Yes	□ No]

## **ADDITIONAL NOTICES**

## [NOTIFICATION REGARDING [MIB, Inc.] [("MIB")] [formerly known as the Medical Information Bureau]

Information regarding your insurability will be treated as confidential. Time Insurance Company or its reinsurers may, however, make a brief report thereon to the [MIB, Inc.,] [formerly known as Medical Information Bureau], a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another [MIB] member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, [MIB,] upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, [MIB] will arrange disclosure of any information in your file. Please contact [MIB] at [866 692-6901] [(TTY 866 346-3642)]. If you question the accuracy of information in [MIB's] file, you may contact [MIB] and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of [MIB's] information office is [50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734].

Time Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life, or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about [MIB] may be obtained on its website at [www.mib.com].]

#### ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

To issue an insurance policy or certificate, we need to obtain information about you and any other person proposed for insurance. Some of that information will be received from you, and some will be generated from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact Time Insurance Company, Underwriting Department, 501 West Michigan, Milwaukee, Wisconsin, 53203.

#### FRAUD NOTICE

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Division of Insurance within the Department of Regulatory Agencies.

#### **PRIVACY**

We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted by law. We collect non-public information about you from the following sources: (1) information we receive from you on enrollment forms or other information related thereto or as part of policy administration, and (2) information about your transactions with our affiliates, others or us. We restrict access to non-public personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your non-public personal information. We may disclose non-public personal information about you to nonaffiliated third parties as permitted by law.

ADDITIONAL NOTES	

## EMPLOYER SPONSORED BUSINESS (ESB) STATEMENT

You understand and agree that you are applying for individual health insurance for you (and your family). You further under	stand that
this application for health insurance will be fully medically underwritten and that coverage is not guaranteed. You are	personally
paying the entire premium for this health insurance coverage. Your employer is not contributing in any way to the p	ayment of
premium, either directly or indirectly. Do you agree with this statement? $\qquad \qquad \Box$	Yes □ No]

## **AUTHORIZATION**

In order to determine my (our) eligibility for insurance, I authorize any licensed physician, medical practitioner, hospital, clinic, any pharmacy, pharmacy benefit manager or pharmacy-related entity, any medically-related facility, insurance company, [MIB, Inc.,] employer, or consumer-reporting agency to give Time Insurance Company (or any consumer-reporting agency authorized by Time Insurance Company) any information regarding me or my family as to employment, other insurance coverage, personal information, and medical or pharmacy care, advice or treatment, or medication use.

I represent to the best of my knowledge and belief, that all statements and answers on Part 1 are complete and true. My recorded Personal Health History, Part 1 and any amendments shall be the basis for the contract. I also agree that: (1) Within 30 days of policy delivery, I must formally accept the offer by verifying the accuracy of the enrollment form information with a signature and returning that signed acceptance to Time Insurance Company. (2) Except as otherwise provided in the Conditional Receipt, the insurance, if approved by Time Insurance Company, will be in force only when issued by Time Insurance Company and accepted by me. (3) I understand and agree that any information I provide through this application process may be shared with persons necessary to facilitate issuing coverage, including but not limited to my agent or broker. (4) If any of these conditions are not met, Time Insurance Company has the right to rescind its offer of coverage and the full extent of its liability shall be limited to the sum received.

[I hereby authorize any health care provider or medically related facility, pharmacy or pharmacy related facility, [MIB, Inc.,] consumer reporting agency, insurance or reinsurance company or employer having information about me or my minor children to provide all such information as may be requested to Time Insurance Company, its legal representative or any medical records retrieval service Time Insurance Company may engage, including, but not limited to, [EMSI] and its agents.]

[This authorization includes any and all information you may have about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, prescription history, lab data and EKGs. This information may also be disclosed to [MIB, Inc.] and any medical records company engaged by Time Insurance Company, including but not limited to [EMSI] and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Time Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. A copy of this authorization will be valid as an original.]

[I understand that this authorization is required in order to enable Time Insurance Company to make eligibility or enrollment determinations relating to me and/or my minor children or for Time Insurance Company's underwriting or risk rating determinations. If I refuse to sign or revoke this authorization, Time Insurance Company may refuse to consider my application for enrollment.]

[I understand that I may revoke this authorization at any time by notifying Time Insurance Company in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, Time Insurance Company, P.O. Box 3050, 501 West Michigan, Milwaukee, WI 53201-3050. Such revocation will not be valid if Time Insurance Company has taken action in reliance on the authorization.]

[Unless an earlier date is required by law, this authorization expires upon the earliest of the following events: [30] days after denial of my application, or declination of enrollment, or, if insured, [30] days after when I am no longer an insured of Time Insurance Company. But in no event will this authorization be in effect for longer than [24] months from the date signed.]

Signature of Primary Proposed Insured		Date Signed	Time Signed	City	State
Signature of Spouse[/Domestic Partner] [/Civil Union] or Other (if proposed to be insured)		Signature(s) of Other Dependent(s) 18 or Over (if proposed to be insured)			
Guardian's Signature					
Requested Effective Date:	Premium Amou	nt Sent: \$	One-time Pr	ocessing Fee Sent	*•

# **Preferred Rating Questionnaire**

Time Insurance Company 501 W. Michigan Street [P.O. Box 624] Milwaukee, WI 53201-0624 [800-800-1212]

Complete this questionnaire to determine eligibility for the Preferred or Preferred Smoker rating classes.

Primary Proposed Insured's Name (please print)

\*Note: A proposed insured *may* be eligible for a Preferred Smoker rating if he or she is able to truthfully answer questions [2,] [3] and [4] "No." Underwriting reserves the right to apply tobacco ratings based upon lab results, phone verification or medical records.

Each proposed insured must complete and sign the appropriate sections. Spouses/Other Insured are considered separately for preferred rating eligibility and must also answer this questionnaire. This information is not required for dependents.

			PRIMARY	SPOUSE /OTHER INSURED
[1.] [Has the proposed insured used tobacco public during the past 3 years? (If NO, go to que	•	time	☐ Yes ☐ No	☐ Yes ☐ No]
[2.] [Did the proposed insured previously smo smoke 10 or more cigarettes per day?	ke or do they o	currently	☐ Yes ☐ No	☐ Yes ☐ No]
[3.] [Did the proposed insured previously smo more than 1 cigar or pipe per day?	ke or do they o	currently smoke	☐ Yes ☐ No	☐ Yes ☐ No]
[4.] [Did the proposed insured previously use chewing tobacco?	or do they cur	rently use	☐ Yes ☐ No	☐ Yes ☐ No]
[5.] [Is the proposed insured currently outside build chart?	e the weight ra	inge listed in the	☐ Yes ☐ No	☐ Yes ☐ No]
[6.] [Has the proposed insured had blood presor been treated for elevated blood press	•		☐ Yes ☐ No	☐ Yes ☐ No]
[7.] [Has the proposed insured had cholestero cholesterol/HDL ratio above 3.5 or been or triglycerides within the past 12 month	treated for ele		☐ Yes ☐ No	☐ Yes ☐ No]
[8.] [Has the proposed insured had any citation violation including speeding ticket(s) with			☐ Yes ☐ No	☐ Yes ☐ No]
[9.] [Has the proposed insured had a complet 3 years?**	e physical exar	n within the past	☐ Yes ☐ No	☐ Yes ☐ No]
** Individuals age 40 and over must have had	a physical exa	ım in the past 3 year:	s to qualify for pre	eferred rates.
Primary Proposed Insured Signature	Date	Spouse or Other Ins	sured Signature	Date
Driver's License Number		Driver's License Nu	mber	
Licensed Agent Signature	Date	Agent Number		<del> </del>

Time Insurance Company 501 W. Michigan Street [P.O. Box 624] Milwaukee, WI 53201-0624 [800-800-1212]

# AMENDMENT OF APPLICATION/ENROLLMENT FORM

I, [John Doe], hereby amend my application/enrollment form to Time Insurance Company dated [December 03, 2009] as follows:

[Insert Amendment Verbiage Here.]

## \*\*\*PLEASE READ AND COMPLETE THE FOLLOWING:\*\*\*

I hereby represent that the above statements are true and complete to the best of my knowledge and belief. I agree that this form shall be an amendment to the original application/enrollment form and of any [policy]/[certificate] issued hereunder. I also agree that no coverage shall be in effect until this form shall have been completed and the full premium paid.

City or Town,		State. Date.	
Signature of Insured (listed above):	X		
		[John Doe] (If minor, legal guardian signature needed)	
[Signature of Owner/Primary Insured:]	X	[	
[Agent's Signature:]	x	[(If minor, legal guardian signature needed)]	

30216

Company Tracking Number: IHAR01145FIF01

TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other

Product Name: Time Insurance-Base Chassis

Project Name/Number: Time Insurance-Base Chassis/IH AR01145FIF01

# **Supporting Document Schedules**

Item Status: Status

Date:

Satisfied - Item: Flesch Certification Approved-Closed 02/17/2010

Comments: Attachment:

AR - READABILITY CERTIFICATION.PDF

Item Status: Status

Date:

Bypassed - Item: Application Approved-Closed 02/17/2010

Bypass Reason: This is an application filing. Please see form schedule.

Comments:

Item Status: Status

Date:

Satisfied - Item: Cover Letter Approved-Closed 02/17/2010

Comments:

Attachment:

Cover Letter.PDF

Item Status: Status

Date:

Satisfied - Item: Statement of variability Approved-Closed 02/17/2010

Comments:

Attachment:

Statement of variability.PDF

#### STATE OF ARKANSAS

#### **READABILITY CERTIFICATION**

### **COMPANY NAME: Time Insurance Company**

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
29300	51.1
29400	51.5
29500	52.3
26566	54.9
30216	53.8

Signed: Name:

Julia Hix-Royer

John Ny - Royce

VP Regulatory Compliance& AH

Title: Compliance Officer

Date: January 28,2010



501 West Michigan P.O. Box 3050 Milwaukee, WI 53201-3050 T 800.800.1212

February 17, 2010

www.assurant.com

Arkansas Department of Insurance 1200 W. Third Street Arkansas Department of Insurance

RE: TIME INSURANCE COMPANY (NAIC #69477; FEIN 39-0658730)

Enrollment Form for Medical Insurance for Individuals and Families: 29300 (Rev.

1/2010)

Tele-App Part 1 Enrollment Form for Medical Insurance for Individuals and

Families: 29400 (Rev. 1/2010)

Tele-App Part 2 Enrollment Form for Medical Insurance for Individuals and

Families: 29500 (Rev. 1/2010)

Preferred Rating Questionnaire: 26566 Amendment of Enrollment form: 30216

Dear Ms. Minor:

In response to the objections raised by you in your SERFF response of February 2, 2010. We have addressed the objections in the same order in which they were presented in your letter

1. The name of the actual insurer/underwriter of the policy must not be so small as to mislead the consumer on the true identity of the insurer. The name of the insurer needs to be in close conjunction and in the same size type as the letters, initials or symbols of Assurant Health.

RESPONSE: The logo has been removed and the font for the insurer/underwriter name has been enlarged.

Thank you in advance for your time and attention to this filing. Should you have any questions, or require additional information, please contact me at any of the numbers listed below.

Assurant Health markets products underwritten by Time Insurance Company, Union Security Insurance Company and John Alden Life Insurance Company.

Best Regards,

Christine R. Fleming

Senior Contract Compliance Analyst

Courtine & Fleming

Legal Department

christine.fleming@assurant.com

T 414.299.1306 or 800.800.1212 ext. 1306

F 414.299.6168



501 West Michigan P.O. Box 3050 Milwaukee, WI 53201-3050 T 800.800.1212

www.assurant.com

#### STATEMENT OF VARIABILITY

- A number of benefit options and/or items which customarily vary according to the Policyholder's specific plan of insurance, which will allow us to deliver a customized contract to our customers reflecting all benefit options selected, helping to alleviate any ambiguity on the part of the customers as to what is covered and how it is covered.
- Flexibility in utilizing provisions when filing diverse products.
- Future flexibility to adjust to changing regulatory and market needs.
  - 1. All bracketed numbers (excluding form numbers) are variable, subject to the confines of state and federal law. Bracketed benefit amounts, illustrated as a range, list of amounts or otherwise, are variable and can fluctuate to provide a richer benefit to the insured than what is represented in the approved document.
  - 2. All bracketed text varies to the extent that such language may be:
    - a. included as shown;
    - b. omitted in its entirety;
    - c. rearranged; or
    - d. transferred to another provision, section or page.
  - 3. All bracketed numbers and/or text will be varied only:
    - a. within any statutory or regulatory requirements; and
    - b. under the condition that the numerical value(s) and benefit language is within the intent and framework of the actual approved provision.

We also reserve the right to amend the form(s) to correct any minor clerical or typographical errors we may have overlooked prior to approval, and to revise any phraseology to clarify the intent within the confines of the law.

Assurant Health markets products underwritten by Time Insurance Company, Union Security Insurance Company and John Alden Life Insurance Company.

 SERFF Tracking Number:
 ASWX-126478651
 State:
 Arkansas

 Filing Company:
 Time Insurance Company
 State Tracking Number:
 44723

Company Tracking Number: IHAR01145FIF01

TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other

Product Name: Time Insurance-Base Chassis

Project Name/Number: Time Insurance-Base Chassis/IH AR01145FIF01

# **Superseded Schedule Items**

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
01/28/2010	Form	Application	02/17/2010	29300.PDF (Superceded)
01/28/2010	Form	Application	02/17/2010	29400.PDF (Superceded)
01/28/2010	Form	Application	02/17/2010	29500.PDF (Superceded)
01/28/2010	Form	Preferred Rating	02/17/2010	26566.PDF (Superceded)
01/28/2010	Form	Amendment	02/17/2010	30216.PDF (Superceded)
01/28/2010	Supporting Document	Cover Letter	02/17/2010	Cover Letter.PDF (Superceded)

# Enrollment Form for Medical Insurance for Individuals and Families

AGENT/AGENC	Y INFORMAT	ION									
Agent Name:				Phone Number:							
Agent Number:				E-mail Address:							
Key Agency Contac	ct:										
Fax Number:				Agency Number:							
[Policy should be r	mailed to:] [[	] Agent] [ $\square$ Age	ncy] [□ Pol	icyhol	der]						
TYPE OF ACTIV	/ITY (Please	check appropriat	e box.)								
[□ NEW] [If not a	new enrollee,	check appropriate	box and list	affect	ed pol	icy number	.]				
[□ CHANGE/ADDIT	ION TO AN EXI	STING POLICY. PO	DLICY #				]				
[ Internal Replacement]						[□ Remov	al/Redu	ction o	f Specia	al Class Premium]	
[ Adding Dependent]						=			-	dent/divorce)]	
[ Removal of Tobacco Rates]						_		_		Existing Policy]	
☐ Applying for		-				=				]	
☐ Removal of Condition Specific Deductible or Special Ex				tion Ri	der]	[□ Reinsta	atement	of Cov	erage]		
PERSON(S) TO	RE INSURED										
1 EN3011(3) 10	DE MOORED										
	Last	Name First	M.I.	Sex	Age	Birthdate MM/DD/YY	State of Birth	Height	Weight	Social Security Number	
1. PRIMARY											
2. SPOUSE [/DOMESTIC PARTNER] [/CIVIL UNION]											
3. DEPENDENT(S)	Last	Name First	м.1.	Sex	Age	Birthdate MM/DD/YY	Full-Time Student?	Height	Weight	Social Security Number	
				•			•		•		
4a. Resident Addr	ess:										
		(Street)			(City)			(State	?)	(ZIP)	
4b. E-mail Addres	ss:										
5. Does any prop	oosed insured	live outside the a	bove househ	old?						□ Yes □ No	
If "Yes," expl	ain										
6. Phone Numbe	er: ()			Г	Pleas	e list the pl	hone nu	mber t	hat wo	ould be the best to	
		inquire about me									

Form 29300 (Rev. 1/2010)

7a.	Primary Insured Occ	cupation:						
	Company Name:		lumber: (	)				
	Duties:							
	-	d [self-employed] [or] [a		_				□ No
	-	d covered by Workers' Co	•					□ No
7b.	Spouse[/Domestic P	artner] [/Civil Union] O	cupation:					
	Company Name:			Work N	lumber: (	)		
	· -	stic Partner] [/Civil Unio						□ No
	Is the Spouse[/Dome	stic Partner] [/Civil Unio	n] covered by	Workers' Cor	npensation?		. ⊔ Yes	□ No
CO	MPLETE IF REQUE	ESTING LIFE INSURAN	ICE COVERA	\GE				
8.	Beneficiary for Prima	ry Insured:	(Full N			(Relat	tionship)	
	Contingent Reneficia	ry:	,	,		(netae	ionsinp)	
	Contingent beneficia	ıy	(Full N			(Relat	tionship)	
	The Primary Insured is the	he beneficiary of any Spouse [	/Domestic Partn	ner] [/Civil Unic	on] or Child(ren) l	ife Insurance.		
01	THER COVERAGE II	N FORCE OR APPLIED	FOR					
					1 6			
[9.]		osed insureds covered by rance?					□Yes	□ No]
	[If "Yes," complete t			• • • • • • • • • • • • • • • • • • • •	•••••••	•••••••	🗆 103	
	Proposed Insured's	Insurance Company	Group or	Type of	Effective Date	Termination	Is this co	verage
	Name	Name	Individual	Coverage	(MM/DD/YY)	Date (MM/DD/YY)	being repl	
							1	
10.]		nsureds covered under thot covered.					□ Yes	□ No] 1
44.1	-							
11.]		posed insureds ever been excluded for life, disabilit						□ No]
		s	•			-		
	. , 3							
HA	AZARDOUS ACTIVIT	TIES AND DRIVING						
42.1	[llave any of the are	nocod incurada [avar] [in	the nest [10]	.aawall mawbia	instead in average	d =i-a		
12.]		posed insureds [ever] [in ited to, automobile, mot				_		
	<del>-</del>	ultralight flying; scuba c			-	_	□ Yes	□ No]
	[If "Yes," indicate:	Who and Which Act	ivity W	hen/How Of	ten Do yo	ou plan contin	ued partic	ipation?
						☐ Yes	□ No	
	_					☐ Yes	□ No	
42.1	Filleria accorded		طاهمات	المام المام	ا بالسائد ال			
13.]		posed insureds been cite ng violations in the past 2		vnile intoxica	tea in the past	co years or	□ Yes	□ No]
		-	-			Dato(c):		-
	[If "Yes," indicate t	ype of violation:				Date(s):		

BILLING		
[□ Monthly Check-O-Matic] [□ Quarterly] [□ Sem	ni-Annual] [□ Annual] [□ List Bill (mont	hly only)]
[Credit Card:] [☐ First Payment Only*] [☐ Monthly	] [□ Quarterly] [□ Semi-Annual]	[□ Annual]
[*With this option, you must select a secondary billing mode for subse	equent payments. Please make selection above and pro	ovide all necessary information.]
If billing address is different than resident address, please cor	mplete:	
Payor Name Address	City	State ZIP
AUTHORIZATION FOR CHECK-O-MATIC BILLING ONLY	′ – Choose the following option that appli	es:
☐ To begin Check-O-Matic withdrawals:		
Select a desired withdrawal day (1–28):	Jane Doe 1234 Any Street Anytown, US 12345	1234
Bank Name:State:		DATE
	PAY TO THE ORDER OF	\$\$
☐ To add this policy to an existing Check-O-Matic:	ANYTOWN BANK	DOLLARS
Existing COM Number:	MEMO	
Associated Policy Number:	$\perp$	(CHECK NUMBER)
	(ROUTING NUMBER - 9 DIGITS) (ACCOUNT NUMBER)	, ,
Routing Number:	Account Number:	
☐ Check-O-Matic (Complete authorization below)  I (we) hereby authorize Time Insurance Company, hereinafter call called DEPOSITORY, indicated on the other side, to debit the same DEPOSITORY have received written notification from me (or either DEPOSITORY a reasonable opportunity to act on it.	e to such account. This authority is to remain in full for	ce and effect until COMPANY and
Signature of Payor	Date Signed	
[AUTHORIZATION FOR CREDIT CARD PAYMENTS		
When selecting MasterCard/VISA Card: I authorize Assurant H I understand there will be no refund of premium after the 10-o		dical policy listed above.
□ VISA Card Number:		
☐ MasterCard Number:		
Exp. Date: / [Security Code Number	(3 digits on back of credit card): $\_\_\_$	_1
Name as it appears on card:		
Signature of Payor:	Date:	]
HEALTH ADVOCATES ALLIANCE MEMBERSHIP	APPI ICATION	

Health Advocates Alliance is a membership organization that promotes good health among its members and their communities. Membership in the Alliance is required in order to be eligible for health insurance coverage. Membership privileges include the opportunity to participate in all programs offered or sponsored by the Association. For additional information and benefits provided by the Association please see the Health Advocates Alliance Brochure (Form JI-1033).

I hereby request enrollment in the Health Advocates Alliance. I understand that nominal dues are required for membership in the Association; if participating in a sponsored insurance program, then my annual dues may be collected in installments along with my insurance premiums. I also understand that membership dues are non-refundable, and my failure to remit membership dues will result in loss of eligibility to participate in any of the Association sponsored programs or benefits.

Member Signature Date

# **HEALTH STATEMENT**

IMPORTANT! PLEASE GIVE COMPLETE DETAILS OF EACH "YES" ANSWER ON THE "ADDITIONAL MEDICAL DETAILS" PAGE.

WITHIN THE LAST 10 YEARS HAS ANY PROPOSED INSURED:

[14.	]HAD	ANY DIAGNOSIS OF, RECEIVED TREATMENT FOR, OR CONSULTED WITH A PHYSICIAN CONCERNI	NG:	
	[a)]	[The lungs or respiratory system including but not limited to: hayfever or other allergies;		
	\ -	sinus infections; asthma; bronchitis; tuberculosis; pneumonia or emphysema?	☐ Yes	□ No]
	[b)]	[The heart or circulatory system including but not limited to: high blood pressure; heart attack; heart murmur; chest pain; irregular heartbeat; varicose veins; phlebitis or elevated cholesterol?	□ Ves	□ No1
		[If "Yes," please provide last known blood pressure and cholesterol reading [on the "Additional Medical Details."		_
	[c)]	[The digestive system including but not limited to: ulcer; gastritis; heartburn; intestinal disorder;		
		colitis; gallbladder; hemorrhoids; hernia; disorder of the pancreas; spleen; or liver including but not limited to; hepatitis; jaundice or cirrhosis?	☐ Yes	□ No1
	[d)]	[The nervous system including but not limited to: epilepsy; seizures; unconsciousness; convulsions		•
	- /-	vertigo; headaches; paralysis; multiple sclerosis; cerebral palsy; Parkinson's disease; stroke or		
		mini-stroke; TIA or brain attack?	☐ Yes	□ No]
	[e)]	[Mental disease or nervous disorder including but not limited to: any emotional disorder; anxiety; depression; attention deficit disorder; eating disorder; or psychiatric treatment or counseling?	□ Yes	□ No]
	[f)]	[Congenital disorder, birth defects or developmental disorders including but not limited to		
		Down Syndrome; mental retardation; autism; cleft palate; club foot; or congenital heart defects?		□ No]
	[g)]	[The genitourinary system including but not limited to: any kidney disorder; kidney stones; cystiti- prostatitis; bladder infections; or sexually transmitted disease?	-	
	[h)]	[Diabetes, high or low blood sugar or any disorder of the thyroid gland or other glandular disorder		-
		[The muscular, skeletal or connective tissue disorder including but not limited to: arthritis;	: 🗆 163	
	ניין	lupus (SLE); temporomandibular joint disease (TMJ); any back or spine disorder or treatment of		
		any muscular or neuromuscular disorder or any manipulation therapy?	☐ Yes	□ No]
		[Blood or lymph disorders including but not limited to anemia or lymphadenopathy? $\dots$		_
	[k)]	[Cancer?		
	F1\7	[If "Yes," provide location, type of cancer and treatment received [on the "Additional Medical De	•	
	[()]	[Tumor, cyst or growth of any kind; any breast or skin disorders?		_
	[m)	[Any disorder of the eyes; ears (including ear infections or ear tubes); nose or throat.  Tonsils or adenoids; any speech or hearing impairment?	□ Yes	□ No]
	[ n-1)	[Any disorder of the reproductive organs, including but not limited to: disorders of the penis; test		-
		vagina; ovaries and cervix; uterus; diagnosed or treated for infertility or irregular menstruation?	☐ Yes	□ No]
	[ n-2)	[To the best of your knowledge, are you, your spouse [/domestic partner] [/civil union] or any		
		dependent now pregnant?		-
		[Is any person not named on this enrollment form now pregnant by any person to be insured?	⊔ Yes	⊔ No]
Г	OUE	ITHER [N-2] OR [N-3] IS ANSWERED "YES," MEDICAL COVERAGE CANNOT BE ISSUED.  STIONS N-4 – N-6 FOR FEMALE APPLICANTS:		
	_	[Complications of pregnancy, including but not limited to caesarean section delivery		
	, .	or miscarriage?	☐ Yes	□ No]
		][Date of Last Pap Smear: Results:		]
	[ n-6)]	][Have you been instructed to have a repeat Pap Smear or any follow-up treatment or tests as a result of your last Pap Smear?	□ Yes	□ No]
∟ .15]	] [Be	en diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS) by a		
_	mer	mber of the medical profession?	☐ Yes	□ No]
[16.		en diagnosed as having or been treated for any immune deficiency disorder by a member of medical profession?	□ Yes	□ No]
[17.	] [Exp	perienced any of the following: Signs and symptoms of an immune deficiency disorder may include		-
		phadenopathy (swollen lymph nodes); loss of appetite; weight loss; chronic fatigue; fever;		
		thrush; skin rashes; unexplained infections; dementia; depression; or other psychoneurotic orders with no known cause?	□ Voc	
[18		d surgery or has diagnostic testing, treatment or surgery been recommended or scheduled that	⊔ ।৫১	⊔ иој
		not been completed?	□ Yes	□ No1

HEALTH STATEMENT C	ONTINUED	روي
	any fixation/prosthetic devices present including but not limited to: plates; (including breast implants); shunts; pacemakers or valve replacements? □ Yes □ No	ol
[20.] [Had an electrocardiog	ram, chest x-ray, or blood test or any other diagnostic testing of any kind or	-
•	in the past 10 years?	oj
	physician or hospital and results [on the Additional Medical Details page].	
counseling for alcoholi	roholics Anonymous or had any treatment, including but not limited to, sm or alcohol abuse or been advised by a physician to discontinue or decrease	ol
[22.] [Used sedatives; tranq	uilizers; cocaine or other hallucinogenic or narcotic drugs; or received treatment	-
_	nical dependency? 🗆 Yes 🗆 No	oj
ADDITIONAL QUESTIONS		
disease or deformity n	nowledge, does any person to be insured have any mental or physical impairment, ot indicated above?	0]
	use [/domestic partner] [/civil union] (if to be insured) smoked cigarettes or irrm or nicotine substitute within the past year? PRIMARY INSURED $\Box$ Yes $\Box$ No	o1
· · · · · · · · · · · · · · · · · · ·		-
-	PARTNER] [/CIVIL UNION] (if to be insured)	υJ
	use [/domestic partner] [/civil union] EVER smoked cigarettes or used 🗆 Yes 🗆 No	0]
[If "Yes," indicate who	o, amount per day and year quit [on the Additional Medical Details page].]	
[25.] [Is any proposed insure	ed currently taking, or taken within the past 12 months, any prescription	
	eiving medical treatment of any kind [or is currently taking, or taken, any	
·	cation on a daily basis]?	0]
[If "Yes," provide deta Additional Medical Det	ils of treatment including name and dosage of all medications [on the	
	OF A SPECIAL CLASS PREMIUM, SPECIAL EXCEPTION RIDER OR CONDITION SPECIFIC DEDUCTIBLE	
REQUESTING THE REMOVAL	OF A SPECIAL CLASS PREMIUM, SPECIAL EXCEPTION RIDER OR CONDITION SPECIFIC DEDUCTIBLE redical treatment or medication use for, or have you consulted with a	
REQUESTING THE REMOVAL  [26.] [Has there been any m physician concerning t	nedical treatment or medication use for, or have you consulted with a he condition(s) which has had a Condition Specific Deductible, been ridered	
REQUESTING THE REMOVAL  [26.] [Has there been any m physician concerning t	nedical treatment or medication use for, or have you consulted with a	
[26.] [Has there been any months of the coverage of the covera	nedical treatment or medication use for, or have you consulted with a he condition(s) which has had a Condition Specific Deductible, been ridered	
[26.] [Has there been any months of the coverage of the covera	nedical treatment or medication use for, or have you consulted with a he condition(s) which has had a Condition Specific Deductible, been ridered ered person's effective date?	
[26.] [Has there been any memory physician concerning to or rated since the covered [If "Yes," provide details.	nedical treatment or medication use for, or have you consulted with a he condition(s) which has had a Condition Specific Deductible, been ridered ered person's effective date?	
[26.] [Has there been any memory physician concerning to or rated since the covered [If "Yes," provide details.	nedical treatment or medication use for, or have you consulted with a he condition(s) which has had a Condition Specific Deductible, been ridered ered person's effective date?	
REQUESTING THE REMOVAL  [26.] [Has there been any many physician concerning to or rated since the covered [If "Yes," provide details.  OTHER PHYSICIANS  [27.] [Regular physician or many physician phys	nedical treatment or medication use for, or have you consulted with a he condition(s) which has had a Condition Specific Deductible, been ridered ered person's effective date?	
REQUESTING THE REMOVAL  [26.] [Has there been any many physician concerning to or rated since the coverage of	nedical treatment or medication use for, or have you consulted with a he condition(s) which has had a Condition Specific Deductible, been ridered ered person's effective date?	
REQUESTING THE REMOVAL  [26.] [Has there been any mean physician concerning to or rated since the coverage of	nedical treatment or medication use for, or have you consulted with a he condition(s) which has had a Condition Specific Deductible, been ridered ered person's effective date?	•] —
REQUESTING THE REMOVAL  [26.] [Has there been any meaning the physician concerning the correct or rated since the cover [If "Yes," provide detained of the cover	nedical treatment or medication use for, or have you consulted with a he condition(s) which has had a Condition Specific Deductible, been ridered ered person's effective date?	o]
REQUESTING THE REMOVAL  [26.] [Has there been any mean physician concerning to or rated since the coverage of	nedical treatment or medication use for, or have you consulted with a he condition(s) which has had a Condition Specific Deductible, been ridered ered person's effective date?	•]
[26.] [Has there been any memory physician concerning to or rated since the covered [If "Yes," provide detained of the covered physician or memory physician or memory physician or memory proposed Instruction [Instruction of the covered physician or memory proposed Instruction of the covered physician or memory physician or memor	nedical treatment or medication use for, or have you consulted with a he condition(s) which has had a Condition Specific Deductible, been ridered ered person's effective date?	0]
REQUESTING THE REMOVAL  [26.] [Has there been any mention physician concerning to or rated since the coverage of the coverage	nedical treatment or medication use for, or have you consulted with a he condition(s) which has had a Condition Specific Deductible, been ridered ered person's effective date?	o] —
REQUESTING THE REMOVAL  [26.] [Has there been any mean physician concerning to or rated since the coverage of	nedical treatment or medication use for, or have you consulted with a he condition(s) which has had a Condition Specific Deductible, been ridered ered person's effective date?	0]
[26.] [Has there been any memory physician concerning to or rated since the covered [If "Yes," provide detained of the covered physician or memory physician or memory physician or memory proposed linear physician or memory physician or memory proposed linear physician or memory physician or me	nedical treatment or medication use for, or have you consulted with a he condition(s) which has had a Condition Specific Deductible, been ridered ered person's effective date?	0]
REQUESTING THE REMOVAL  [26.] [Has there been any memory physician concerning to or rated since the covered life "Yes," provide detained of the covered life "Yes," provide detained life "Yes," provide life "Yes	nedical treatment or medication use for, or have you consulted with a he condition(s) which has had a Condition Specific Deductible, been ridered ered person's effective date?	0]
REQUESTING THE REMOVAL  [26.] [Has there been any mean physician concerning to or rated since the coverage of	hedical treatment or medication use for, or have you consulted with a he condition(s) which has had a Condition Specific Deductible, been ridered hered person's effective date?	0]
REQUESTING THE REMOVAL  [26.] [Has there been any memory physician concerning to or rated since the cover concerning to or rated since the cover	nedical treatment or medication use for, or have you consulted with a he condition(s) which has had a Condition Specific Deductible, been ridered ered person's effective date?	0]
REQUESTING THE REMOVAL  [26.] [Has there been any memory physician concerning to or rated since the coverage of the coverage o	nedical treatment or medication use for, or have you consulted with a he condition(s) which has had a Condition Specific Deductible, been ridered ered person's effective date?	
REQUESTING THE REMOVAL  [26.] [Has there been any memory physician concerning to or rated since the coverage of the coverage o	redical treatment or medication use for, or have you consulted with a he condition(s) which has had a Condition Specific Deductible, been ridered ered person's effective date?	

# ADDITIONAL MEDICAL DETAILS

Attach a separate sheet if additional space is needed. Date and sign any additional sheets.

	Provide Dates, Type of Treatment and Results	Name of Doctor/Hospital and Complete Address and Phone Number
Person:		
Condition:		
Question #:		
Person:		
Condition:		
Question #:		
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#### HIPAA ELIGIBILITY

[Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), certain individuals have a guaranteed right to an individual plan without a pre-existing exclusion. In order for Time Insurance Company to determine whether you or anyone applying for coverage is entitled to such a plan, please review the following and indicate whether ALL of the following statements are true at the time you or anyone to be insured apply for individual coverage:

- You have at least 18 months of continuous creditable coverage without any break in coverage greater than 63 days.
- Your most recent coverage was under a group plan, a governmental plan or a church plan.
- You are not covered under another group health plan.
- Your most recent coverage was not cancelled because you did not pay premiums or because you committed fraud.
- You are not currently eligible for Medicare or Medicaid.
- You have exhausted any continuation of coverage (COBRA or state continuation) for which you were eligible.
- $\ \square$  No, I or anyone to be insured do not meet one or more of the foregoing requirements.
- $\square$  Yes, I or anyone to be insured meet all of the foregoing requirements.]

#### **AUTHORIZATION**

[I represent to the best of my knowledge and belief, that all statements and answers on this enrollment form are complete and true. The enrollment form and any amendments shall be the basis for the contract. I also agree that:

Except as otherwise provided in the Conditional Receipt, the insurance, if approved by Time Insurance Company, will be in force only when issued by Time Insurance Company. The first full premium must be paid. Coverage will become effective on the later of: A) The date we receive the enrollment form; B) the requested Effective Date. A change in the health of the proposed insured(s) after the completion of the enrollment form and before the delivery of the contract may affect my eligibility for insurance with the company. The contract may only be effective prior to the contract delivery subject to the terms of the Conditional Receipt.]

[I agree that a photographic copy of this authorization shall be valid for two years from the date signed.]

[I acknowledge receiving the notification regarding the Medical Information Bureau, the Abbreviated Notice of Insurance Information Practices and the Outline of Coverage for Health Insurance, if required.]

[We, the undersigned Proposed Insured(s) and agent, acknowledge that the Proposed Insured(s) has read the completed enrollment form. We understand and acknowledge that any fraudulent statement or material misrepresentation or omission on the enrollment form and/or any amendments may result in claim denial or contract rescission, subject to the time limit on certain defenses or incontestability provisions of the contract.]

[I hereby authorize any health care provider or medically related facility, pharmacy or pharmacy related facility, the Medical Information Bureau, Inc., consumer reporting agency, insurance or reinsurance company or employer having information about me or my minor children to provide all such information as may be requested to Time Insurance Company, its legal representative or any medical records retrieval service Time Insurance Company may engage, including, but not limited to, EMSI and its agents.]

[This authorization includes any and all information you may have about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, prescription history, lab data and EKGs. This information may also be disclosed to the Medical Information Bureau, Inc. and any medical records company engaged by Time Insurance Company, including but not limited to EMSI and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Time Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. A copy of this authorization will be valid as an original.]

[I understand that this authorization is required in order to enable Time Insurance Company to make eligibility or enrollment determinations relating to me and/or my minor children or for Time Insurance Company's underwriting or risk rating determinations. If I refuse to sign or revoke this authorization, Time Insurance Company may refuse to consider my application for enrollment.]

[I understand that I may revoke this authorization at any time by notifying Time Insurance Company in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, Time Insurance Company, P.O. Box 3050, 501 West Michigan, Milwaukee, WI 53201-3050. Such revocation will not be valid if Time Insurance Company has taken action in reliance on the authorization.]

[Unless an earlier date is required by law, this authorization expires upon the earliest of the following events: [30] days after denial of my application, or declination of enrollment, or, if insured, [30] days after when I am no longer an insured of Time Insurance Company. But in no event will this authorization be in effect for longer than [24] months from the date signed.]

		A.M. / P.M.					
Signature of Primary Proposed Insured	Date Signed	Time Signed	City	State			
Signature of Spouse[/Domestic Partner] [/Civil Union] or Other (if proposed to be insured)	Attention: (Agent) I have reviewed the items have been of	nis enrollment form to	ensure that all r	equired			
		wledge, there $\Box$ <b>IS</b> [nce involved in this tra		cement			
Signature(s) of Other Dependent(s) 18 or Over (if proposed to be insured)	Are you aware of any mental or physical impairment, disease, or deformity of any proposed insured which is not disclosed on the enrollment form? ☐ Yes ☐ No						
Guardian's Signature	If "Yes," please ex	xplain					
Requested Effective Date:							
Premium Amount Sent: \$		Licensed Resident Agent	's Signature				
One-time Processing Fee Sent*: *Not applicable in all states		Print Agent's Na	me				
Conditional Receipt Taken: ☐ Yes ☐ No		ere if you witnessed the s d insured.	igning of this form	by the			

#### **ADDITIONAL NOTICES**

#### [NOTIFICATION REGARDING [MIB, Inc.] [("MIB")] [formerly known as the Medical Information Bureau]

Information regarding your insurability will be treated as confidential. Time Insurance Company or its reinsurers may, however, make a brief report thereon to [the] [MIB, Inc.,] [formerly known as Medical Information Bureau], a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another [MIB] member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, [MIB], upon request, will supply such company with the information in its file.

Upon receipt of a request from you, [MIB] will arrange disclosure of any information it may have in your file. Please contact [MIB] at [866 692-6901] [(TTY 866 346-3642)]. If you question the accuracy of information in [MIB's] file, you may contact [MIB] and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of [MIB's] information office is [50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734].

Time Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life, or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about [MIB] may be obtained on its website at [www.mib.com].]

#### ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

To issue an insurance policy or certificate, we need to obtain information about you and any other person proposed for insurance. Some of that information will be received from you, and some will be generated from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact Time Insurance Company, Underwriting Department, 501 West Michigan, Milwaukee, Wisconsin, 53203.

#### FRAUD NOTICE

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Division of Insurance within the Department of Regulatory Agencies.

#### **PRIVACY**

We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted by law. We collect non-public information about you from the following sources: (1) information we receive from you on enrollment forms or other information related thereto or as part of policy administration, and (2) information about your transactions with our affiliates, others or us. We restrict access to non-public personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your non-public personal information. We may disclose non-public personal information about you to nonaffiliated third parties as permitted by law.

#### **CONDITIONAL RECEIPT**

This Conditional Receipt is received from	_, this	_ day of
(month) (year).		
If full premium is paid and Time Insurance Company accepts this application as applied the application is signed, the effective date will be as specified above, but I agree that	it I have no insurance	coverage
under this application until Time Insurance Company notifies me in writing that my ap	plication is approved.	No agent or
broker of the Company is authorized to alter or waive the conditions of this conditional	al receipt.	

For coverage to become effective, each individual to be covered must be a risk acceptable to Time Insurance Company as applied for and at a standard or preferred rate with no Special Exception Riders on the later of: the Requested Effective Date or the Date on which Time Insurance Company receives the application at its home office.

I understand that Time Insurance Company has the right to deny my application and if it does so I will be notified in writing and the premium I submitted will be returned.

If I do not select an effective date, Time Insurance Company will assign an effective date that is later than the date the application is approved.

I must advise Time Insurance Company of any change in information included in the application for me or any person to be insured that occurs after the date I sign the application until the later of the effective date of coverage or the date Time Insurance Company receives the application at its home office. Failure to update Time Insurance Company regarding these changes may result in coverage being voided.

# Tele-App Part 1 Enrollment Form for Medical Insurance for Individuals and Families

#### PLEASE PRINT IN BLACK INK

AGENT/AGENCY	INFO	RMATION							
Agent Name:				Phone Number:					
Agent Number:				E-mail Address:					
Key Agency Contact	:			Agency l	Name:				
Fax Number:				Agency l	Numbe	er:			
[Policy should be m	ailed to	:] [□ Agent] [□ Agend	cy] [□ Polic	cyholder]					
TYPE OF ACTIVI	TY (Pl	ease check appropriate	box.)						
		llee, check appropriate b		ıffected p	oolicy	number.]			
[ CHANGE/ADDITION	ON TO A	N EXISTING POLICY. POL	ICY #			]			
☐ Internal Repla ☐ Adding Depen ☐ Removal of To ☐ Applying for P ☐ Removal of Co	dent] bacco R referrec	ates]	ecial Excepti	ion Rider <u>i</u>	- [□	Conversion ( Policy/Benet	over age fit Change hange Reque	f Special Class Premium] dependent/divorce)] e to an Existing Policy] ested:] rerage]	
PERSON(S) TO B	E INSU	IRED							
		Name		Sex	Age	Birthdate	State	Social Security Number	
4. DD144.DV	Last	First	MI			(MM/DD/YY)	of Birth		
1. PRIMARY 2. SPOUSE[/ DOMESTIC PARTNER] [/CIVIL UNION]									
3. DEPENDENT(S) (list relationship)	Last	<b>Name</b> First	МІ	Sex	Age	Birthdate (MM/DD/YY)	Full-time Student?	Social Security Number	
4. Resident Address (NO P.O. BOXES)	s:	(Street)		(City)			(State)	(ZIP)	
		)							
, ,	•	insureds covered by any	, , ,						
Proposed Insured' Name		Insurance Company Name	Group or Individual	Type Cover	of	Effective Date (MM/DD/YY)	Termina Date	tion Is this coverage being replaced by	
							(11010 001	proposed corerage:	

7b. [Primary Insured Occupation:	
	Work Number: ()
	ole proprietor]?
	upation:
	Work Number: ()
	o] [self-employed] [or] [a sole proprietor]? □ Yes □ N o] covered by Workers' Compensation?? □ Yes □ N
BILLING	
[□ Monthly Check-O-Matic] [□ Quarterly] [□ Ser	mi-Annual] [  Annual] [  List Bill (monthly only)]
[Credit Card:] [☐ First Payment Only*] [☐ Monthly	ly] $[\Box$ Quarterly] $[\Box$ Semi-Annual] $[\Box$ Annual]
[*With this option, you must select a secondary billing mode for subs	osequent payments. Please make selection above and provide all necessary informat
If billing address is different than resident address, please co	ompleter
in bitting address is different than resident address, please co	omplete.
Payor Name Address	City State ZII
AUTHORIZATION FOR CHECK-O-MATIC BILLING ONL	LY — Choose the following option that applies:
☐ To begin Check-O-Matic withdrawals:	Jane Doe 1234
Select a desired withdrawal day (1–28): Bank Name:	American IIC 4224E
City: State:	
☐ To add this policy to an existing Check-O-Matic:	PAY TO THE ORDER OF
Existing COM Number:	DOLLARS ANYTOWN BANK
Associated Policy Number:	MEMO
Associated Folicy Numbers	(ROUTING NUMBER - 9 DIGITS) (ACCOUNT NUMBER) (CHECK NUMB
Routing Number:	Account Number:
called DEPOSITORY, indicated on the other side, to debit the same	lled COMPANY, to initiate debit entries to the account and depository, hereinafter le to such account. This authority is to remain in full force and effect until COMPANY er of us) of its termination in such time and in such manner as to afford COMPANY and
Signature of Payor	Date Signed
[AUTHORIZATION FOR CREDIT CARD PAYMENTS	
	Health to charge my account for the Individual Medical policy listed above. 0-day free look period in the contract.
□ VISA Card Number:	
☐ MasterCard Number:	
Exp. Date: / [Security Code Number	
Name as it appears on card:	
Signature of Payor:	

# COMPLETE IF REQUESTING LIFE INSURANCE COVERAGE Beneficiary for Primary Insured: \_\_\_ (Full Name) (Relationship) Contingent Beneficiary: \_\_\_ (Full Name) (Relationship) The Primary Insured is the beneficiary of any Spouse [/Domestic Partner] [/Civil Union] or Child(ren) Life Insurance. HEALTH ADVOCATES ALLIANCE MEMBERSHIP APPLICATION Health Advocates Alliance is a membership organization that promotes good health among its members and their communities. Membership in the Alliance is required in order to be eligible for health insurance coverage. Membership privileges include the opportunity to participate in all programs offered or sponsored by the Association. For additional information and benefits provided by the Association please see the Health Advocates Alliance Brochure (Form JI-1033). I hereby request enrollment in the Health Advocates Alliance. I understand that nominal dues are required for membership in the Association; if participating in a sponsored insurance program, then my annual dues may be collected in installments along with my insurance premiums. I also understand that membership dues are non-refundable, and my failure to remit membership dues will result in loss of eligibility to participate in any of the Association sponsored programs or benefits. Member Signature Date **HIPAA ELIGIBILITY** [Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), certain individuals have a guaranteed right to an individual plan without a pre-existing exclusion. In order for Time Insurance Company to determine whether you or anyone applying for coverage is entitled to such a plan, please review the following and indicate whether ALL of the following statements are true at the time you or anyone to be insured apply for individual coverage: You have at least 18 months of continuous creditable coverage without any break in coverage greater than 63 days. Your most recent coverage was under a group plan, a governmental plan or a church plan. You are not covered under another group health plan. Your most recent coverage was not cancelled because you did not pay premiums or because you committed fraud. You are not currently eligible for Medicare or Medicaid. You have exhausted any continuation of coverage (COBRA or state continuation) for which you were eligible. □ No. I or anyone to be insured do not meet one or more of the foregoing requirements. ☐ Yes, I or anyone to be insured meet all of the foregoing requirements.]

#### **EMPLOYER SPONSORED BUSINESS (ESB) STATEMENT**

You understand and agree that you are applying for individual health insurance for you (and your family). You understand that this application for health insurance will be fully medically underwritten and that coverage guaranteed. You are personally paying the entire premium for this health Insurance coverage. Your employed and the paying the forestime either directly are indirectly.	e is not
contributing in any way to the payment of premium, either directly or indirectly.  Do you agree with this statement?	□ No Ì

#### **AUTHORIZATION**

In order to determine my (our) eligibility for insurance, I authorize any licensed physician, medical practitioner, hospital, clinic, any pharmacy, pharmacy benefit manager or pharmacy-related entity, any medically-related facility, insurance company, the Medical Information Bureau, employer, or consumer-reporting agency to give Time Insurance Company (or any consumer-reporting agency authorized by Time Insurance Company) any information regarding me or my family as to employment, other insurance coverage, personal information, and medical or pharmacy care, advice or treatment, or medication use.

I represent to the best of my knowledge and belief, that all statements and answers on Part 1 are complete and true. My recorded Personal Health History, Part 1 and any amendments shall be the basis for the contract. I also agree that: (1) I must call Time Insurance Company and complete the Personal Health History portion of the enrollment process within 10 days of commencement of the enrollment process and subsequently provide any and all medical information related thereto. (2) Within 30 days of policy delivery, I must formally accept the offer by verifying the accuracy of the enrollment form information with a signature and returning that signed acceptance to Time Insurance Company. (3) Except as otherwise provided in the Conditional Receipt, the insurance, if approved by Time Insurance Company, will be in force only when issued by Time Insurance Company and accepted by me. (4) I understand and agree that any information I provide through this application process may be shared with persons necessary to facilitate issuing coverage, including but not limited to my agent or broker. (5) If any of these conditions are not met, Time Insurance Company has the right to rescind its offer of coverage and the full extent of its liability shall be limited to the sum received.

[I hereby authorize any health care provider or medically related facility, pharmacy or pharmacy related facility, the Medical Information Bureau, Inc., consumer reporting agency, insurance or reinsurance company or employer having information about me or my minor children to provide all such information as may be requested to Time Insurance Company, its legal representative or any medical records retrieval service Time Insurance Company may engage, including, but not limited to, EMSI and its agents.]

[This authorization includes any and all information you may have about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, prescription history, lab data and EKGs. This information may also be disclosed to the Medical Information Bureau, Inc. and any medical records company engaged by Time Insurance Company, including but not limited to EMSI and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Time Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. A copy of this authorization will be valid as an original.]

[I understand that this authorization is required in order to enable Time Insurance Company to make eligibility or enrollment determinations relating to me and/or my minor children or for Time Insurance Company's underwriting or risk rating determinations. If I refuse to sign or revoke this authorization, Time Insurance Company may refuse to consider my application for enrollment.]

[I understand that I may revoke this authorization at any time by notifying Time Insurance Company in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, Time Insurance Company, P.O. Box 3050, 501 West Michigan, Milwaukee, WI 53201-3050. Such revocation will not be valid if Time Insurance Company has taken action in reliance on the authorization.]

[Unless an earlier date is required by law, this authorization expires upon the earliest of the following events: [30] days after denial of my application, or declination of enrollment, or, if insured, [30] days after when I am no longer an insured of Time Insurance Company. But in no event will this authorization be in effect for longer than [24] months from the date signed.]

Signature of Primary Propo	sed Insured	Signature of Spouse or O	ther Insured (if proposed to be insured)
	(Circle one) A.M. / P.M.		
Date Signed	Time Signed	City & State	Requested Policy Effective Date
Conditional Receipt Give	n? □ Yes □ No		

[REMEMBER TO FAX PAGES 1, 2, 3 & 4 AND THE SOFTWARE PROPOSAL TO [414-299-6020]]

#### **ADDITIONAL NOTICES**

#### [NOTIFICATION REGARDING [MIB, Inc.] [("MIB")] [formerly known as the Medical Information Bureau]

Information regarding your insurability will be treated as confidential. Time Insurance Company or its reinsurers may, however, make a brief report thereon to [the] [MIB, Inc.,] [formerly known as Medical Information Bureau], a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another [MIB] member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, [MIB], upon request, will supply such company with the information in its file.

Upon receipt of a request from you, [MIB] will arrange disclosure of any information it may have in your file. Please contact [MIB] at [866 692-6901] [(TTY 866 346-3642)]. If you question the accuracy of information in [MIB's] file, you may contact [MIB] and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of [MIB's] information office is [50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734].

Time Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life, or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about [MIB] may be obtained on its website at [www.mib.com].]

#### ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

To issue an insurance policy or certificate, we need to obtain information about you and any other person proposed for insurance. Some of that information will be received from you, and some will be generated from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact Time Insurance Company, Underwriting Department, 501 West Michigan, Milwaukee, Wisconsin, 53203.

#### **FRAUD NOTICE**

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Division of Insurance within the Department of Regulatory Agencies.

#### **PRIVACY**

We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted by law. We collect non-public information about you from the following sources: (1) information we receive from you on enrollment forms or other information related thereto or as part of policy administration, and (2) information about your transactions with our affiliates, others or us. We restrict access to non-public personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your non-public personal information. We may disclose non-public personal information about you to nonaffiliated third parties as permitted by law. ]

#### **CONDITIONAL RECEIPT**

This Conditional Receipt is received from	, this	day of	(month)
(year).			

If full premium is paid and Time Insurance Company accepts this application as applied for within (30) days of the date the application is signed, the effective date will be as specified above, but I agree that I have no insurance coverage under this application until Time Insurance Company notifies me in writing that my application is approved. No agent or broker of the Company is authorized to alter or waive the conditions of this conditional receipt.

For coverage to become effective, each individual to be covered must be a risk acceptable to Time Insurance Company as applied for and at a standard or preferred rate with no Special Exception Riders on the later of: the Requested Effective Date or the Date on which the Personal Health History call is completed.

I understand that Time Insurance Company has the right to deny my application and if it does so I will be notified in writing and the premium I submitted will be returned. If I do not select an effective date, Time Insurance Company will assign an effective date that is later than the date the application is approved.

I must advise Time Insurance Company of any change in information included in the application for me or any person to be insured that occurs after the date I sign the application until the later of the effective date of coverage or the date on which the Personal Health History call is completed. Failure to update Time Insurance Company regarding these changes may result in coverage being voided.



501 West Michigan P.O. Box 3050 Milwaukee, WI 53201-3050 T 800.800.1212

January 29, 2010

www.assurant.com

Arkansas Department of Insurance 1200 W. Third Street Arkansas Department of Insurance

RE: TIME INSURANCE COMPANY (NAIC #69477; FEIN 39-0658730)

Enrollment Form for Medical Insurance for Individuals and Families: 29300 (Rev.

1/2010)

Tele-App Part 1 Enrollment Form for Medical Insurance for Individuals and

Families: 29400 (Rev. 1/2010)

Tele-App Part 2 Enrollment Form for Medical Insurance for Individuals and

Families: 29500 (Rev. 1/2010)

Preferred Rating Questionnaire: 26566 Amendment of Enrollment form: 30216

#### Dear Sir or Madam:

The above-referenced forms are submitted for your review and approval: Enrollment Form for Medical Insurance for Individuals and Families, 29300 (Rev. 1/2010), 29400 (Rev. 1/2010) and 29500 (Rev. 1/2010).

Form number 29300 is completed when an applicant is applying for coverage through the paper application process. The form series 29400 and 29500 are completed when an applicant is applying for coverage through the telephone application process, an online process or software based process.

Also enclosed are a Preferred Rating Questionnaire and an Amendment to the enrollment form. The amendment is used when the consumer wants to amend their response to a question on a previously completed application.

All forms are subject to minor modifications in paper size, stock, layout, format, company logo and printing specifications of the document upon issue. As mentioned above, some of the provisions/sections are bracketed to provide flexibility as well as to afford future flexibility to adjust to changing regulatory and market needs. Please see the enclosed Statement of Variability for additional information on form adaptability.

Upon approval, the amended forms will be used to market major medical insurance to individuals by independent agents licensed in your state.

Assurant Health markets products underwritten by Time Insurance Company, Union Security Insurance Company and John Alden Life Insurance Company.

Please note that Wisconsin is the state domicile for Time Insurance Company. The state of Wisconsin does not require the filing of forms that are being marketed for out-of-state use with their office.

Thank you in advance for your time and attention to this filing. Should you have any questions, or require additional information, please contact me at any of the numbers listed below.

Best Regards,

Christine R. Fleming

Senior Contract Compliance Analyst

Countine & Fleming

Legal Department

christine.fleming@assurant.com

T 414.299.1306 or 800.800.1212 ext. 1306

F 414.299.6168

Policy #:			
,			

# **Acceptance of Offer and Attestation**

I represent to the best of my knowledge and belief, that all statements and answers on this enrollment form are complete and true. My recorded Personal Health History, the enrollment form and any amendments shall be the basis for the offer of coverage. I also agree that:

Except as otherwise provided in the Conditional Receipt, the insurance, if approved by Time Insurance Company, will be in force only when issued by Time Insurance Company. I shall sign the enrollment form and obtain the signatures of my [Spouse] [Domestic Partner] [Civil Union] and any covered dependents over the age of 18, and return it to Time Insurance Company within 30 days of the contract issue. If acceptance is not received within 30 days, Time Insurance Company reserves the right to revoke any and all such offers. The first full premium must be paid. The contract may only be effective prior to the contract delivery and acceptance, if all the terms of the Conditional Receipt have been fulfilled.

I agree that a photocopy of this authorization shall be valid for two years from the date signed. I acknowledge receiving the Fair Credit Reporting Act Pre-Notification, the notification regarding the Medical Information Bureau, the Privacy statement concerning my personal health information, the Abbreviated Notice of Insurance Information Practices, and the Outline of Coverage for Health Insurance, if required.

We, the undersigned proposed insured(s) and agent acknowledge that the proposed insured(s) has read the completed enrollment form. We understand and acknowledge that any fraudulent statement or material misrepresentation on the enrollment form and/or any amendments may result in claim denial or contract rescission, subject to the time limit on certain defenses or incontestability provisions of the contract.

Signature of Proposed Insure	ed	
Date Signed	State	If Life Insurance is issued, complete this section.  Beneficiary for Primary Insured:
Signature of Spouse or Other I		Full Name and Relationship  Contingent Beneficiary:
Signature(s) of Other Depende Guardian's Signature	ents 18 or Over	Full Name and Relationship  (The Primary Insured is the Beneficiary of any spouse [/domestic partner] [/civil union] or child(ren) life insurance.)

# Enrollment Form for Medical Insurance for Individuals and Families

AGENT/AGENCY	INFORMATI	ON								
Agent Name:				Phone	Numb	er:				
Agent Number:				E-mail	Addre	ess:				
Key Agency Contact:	:			Agency	/ Nam	e:				
Fax Number:				Agency	/ Num	ber:				
[Policy should be ma	ailed to:] [🗆 .	Agent] [□ Agen	cy] [🗆 Polic	cyholde	r]					
TYPE OF ACTIVI	TY (Please c	heck appropriate	e box.)							
[□ NEW] [If not a ne	ew enrollee, ch	neck appropriate	box and list c	affected	l polic	y number.]	1			
☐ CHANGE/ADDITIO	N TO AN EXIST	TING POLICY. PO	LICY #		-		]			
[ Internal Replac	cement]				I	☐ Remova	l/Reduct	ion of	Special	Class Premium]
☐ Adding Depend	_				-	-	,	•	•	nt/divorce)]
<ul><li>[□ Removal of Tob</li><li>[□ Applying for Property of the complex of the</li></ul>	=				ſ	-		_		kisting Policy]
☐ Removal of Co	-		ecial Except	ion Ride	er] [	Reinstat	-	-		J
PERSON(S) TO B	E INSURED									
		Name		Sex	Age	Birthdate	State	Height	Weight	Social Security Number
	Last	First	М.І.	Jex	Age	MM/DD/YY	of Birth	rieigiic	Weight	Social Security Number
1. PRIMARY										
2. SPOUSE [/DOMESTIC PARTNER] [/CIVIL UNION]										
3. DEPENDENT(S)	Last	Name First	м.1.	Sex	Age	Birthdate MM/DD/YY	Full-Time Student?	Height	Weight	Social Security Number
				•	,	•	,	•		•
4a. Resident Addr	ess:	(Street)			(City)			(State	 e)	(ZIP)
4b. E-mail Address	<b>د.</b>	` ,						,	,	, ,
										□ Voa □ Na1
		live outside the								□ Yes □ No]
				_		•				ould be the best to
reach you dur	ing the day to	inquire about m	edical histor	y. (		_)				_]

	Company Name: _			Work I	Number: (	)		
	Duties:							
	-	red [self-employed] [or] [a		_				
	Is the Primary Insu	red covered by Workers' Co	ompensation?.				. □ Yes	
7b.]	Spouse[/Domestic	Partner] [/Civil Union] 0	ccupation:					
	Company Name: _			Work I	Number: (	)		
		nestic Partner] [/Civil Unio				_		□ 1
	Is the Spouse[/Dom	nestic Partner] [/Civil Unio	n] covered by	Workers' Co	mpensation?		. ⊔ Yes	
	[Are any of the pro	posed insureds covered by surance?	, or has applic		•		. □Yes	□ <b>1</b>
	in les, complete	the section below.						
F	Proposed Insured's Name	Insurance Company Name	Group or Individual	Type of Coverage	Effective Date (MM/DD/YY)	Termination Date (MM/DD/YY)	ls this co being repl proposed c	aced by
[9.]	[Were all proposed	insureds covered under th	ne prior plan li	sted above?			□ Yes	<u> </u>
[9.]	-	insureds covered under the						1
	[If "No," list those [Have any of the pr reformed, charged medical insurance?		e last [10] yea a portion of co	rs] been dec verage exclu	lined, postpone ded for life, di	ed, rescinded, sability, or	□ Yes	
	[If "No," list those [Have any of the pr reformed, charged medical insurance?	not covered roposed insureds [within th an extra premium or had a	e last [10] yea a portion of co	rs] been dec verage exclu	lined, postpone ded for life, di	ed, rescinded, sability, or	□ Yes	
	[If "No," list those [Have any of the pr reformed, charged medical insurance?	not covered roposed insureds [within th an extra premium or had a	e last [10] yea a portion of co	rs] been dec verage exclu	lined, postpone ded for life, di	ed, rescinded, sability, or	□ Yes	
	[If "No," list those [Have any of the pr reformed, charged medical insurance?	not covered roposed insureds [within th an extra premium or had a	e last [10] yea a portion of co	rs] been dec verage exclu	lined, postpone ded for life, di	ed, rescinded, sability, or	□ Yes	
	[If "No," list those [Have any of the pr reformed, charged medical insurance?	not covered roposed insureds [within th an extra premium or had a	e last [10] yea a portion of co	rs] been dec verage exclu	lined, postpone ded for life, di	ed, rescinded, sability, or	□ Yes	
	[If "No," list those [Have any of the pr reformed, charged medical insurance?	not covered roposed insureds [within th an extra premium or had a	e last [10] yea a portion of co	rs] been dec verage exclu	lined, postpone ded for life, di	ed, rescinded, sability, or	□ Yes	
10.]	[If "No," list those [Have any of the pr reformed, charged medical insurance? [If "Yes," give deta	not covered roposed insureds [within th an extra premium or had a 	e last [10] yea a portion of co	rs] been dec verage exclu	lined, postpone ded for life, di	ed, rescinded, sability, or	□ Yes	
10.]	[If "No," list those [Have any of the pr reformed, charged medical insurance? [If "Yes," give deta	not covered roposed insureds [within th an extra premium or had a	e last [10] yea a portion of co	rs] been dec verage exclu	lined, postpone ded for life, di	ed, rescinded, sability, or	□ Yes	
HAZ	[If "No," list those [Have any of the pr reformed, charged medical insurance? [If "Yes," give deta  ARDOUS ACTIVIT  [In the last [10] yes (includes drivers, p	roposed insureds [within the an extra premium or had a	e last [10] yea a portion of co 	rs] been dec verage exclu ····································	lined, postpone ded for life, dis 	ed, rescinded, sability, or	□ Yes	
HAZ	[If "No," list those [Have any of the pr reformed, charged medical insurance? [If "Yes," give deta  ARDOUS ACTIVIT  [In the last [10] yes (includes drivers, p ultralight flying, so	roposed insureds [within the an extra premium or had a	sed insureds phics) or any of ock or mounta	rs] been dec verage exclu  articipated i the followin in climbing o	lined, postponed ded for life, dis the second of the secon	d vehicle racingdiving,	□ Yes	

BILLING					
[ Monthly Check-O-Matic] [	Quarterly] [ Semi-A	Annual] [□ Annual]	[□ List Bill (monthly	only)]	
[Credit Card:] [ First Paymen	nt Only*] [□ Monthly]	[□ Quarterly] [[	☐ Semi-Annual]	[□ Annual]	
			-		
[*With this option, you must select a secon	naary billing mode for subsequ	ent payments. Please make se	election above ana provi	ae all necessary informa	ition. J
If billing address is different than resi	ident address, please comp	lete:			
Payor Name	Address	Cit	у	State Z	IP
AUTHORIZATION FOR CHECK-O	-MATIC BILLING ONLY	- Choose the following	option that applies	5:	
☐ To begin Check-O-Matic witho	Irawals:				4
Select a desired withdrawal da	ay (1-28):	Jane Doe 1234 Any Street		1234	
Bank Name:		Anytown, US 12345	-15	DATE	
City:	State:	PAY TO THE ORDER OF	-VAMPLE	\$	
$\ \square$ To add this policy to an existi	ng Check-O-Matic:	PAY TO THE ORDER OF	EXA	DOLLARS	
Existing COM Number:		ANYTOWN BANK			
Associated Policy Number:		MEMO 123456789	0987654321	1234	
		(ROUTING NUMBER - 9 DIGITS)	(ACCOUNT NUMBER)	(CHECK NUM	ABER)
Routing Number				(CHECK NUM	ABER)
Routing Number:			(ACCOUNT NUMBER)  Dunt Number:	(CHECK NUM	ABER)
Routing Number:				(CHECK NUM	ABER)
	rization below) • Company, hereinafter called C • ther side, to debit the same to • ification from me (or either of	Accordance	ount Number:	epository, hereinafter and effect until COMPANY	Y and
☐ Check-O-Matic (Complete author I (we) hereby authorize Time Insurance called DEPOSITORY, indicated on the of DEPOSITORY have received written not	rization below) • Company, hereinafter called C • ther side, to debit the same to • ification from me (or either of	Acco	ount Number:	epository, hereinafter and effect until COMPANY	Y and
Check-O-Matic (Complete author I (we) hereby authorize Time Insurance called DEPOSITORY, indicated on the ot DEPOSITORY have received written not DEPOSITORY a reasonable opportunity to	rization below) c Company, hereinafter called Cher side, to debit the same to ification from me (or either of to act on it.	Accordance COMPANY, to initiate debit entriports account. This authority is us) of its termination in such to	ount Number:	epository, hereinafter and effect until COMPANY	Y and
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# **HEALTH STATEMENT**

For Questions 13-25, WITHIN THE LAST [10] YEARS, HAS ANY PROPOSED INSURED:	
[Note: any follow-up visits in the last [10] years as a result of a diagnosis over [10] years ago must be disclosed.]	
[13.] [Had surgery [in a hospital or outpatient facility]? $\ \square$ Yes	□ No]
[14.] [Had medical treatment [in a hospital or outpatient facility] [other than already disclosed]? $\Box$ Yes	□ No]
[15.] [Had any urgent care or emergency room visits [not disclosed in Questions [13] & [14]]? $\Box$ Yes	□ No]
[16.] [Received treatment, testing, consulted with or received a diagnosis from a physician or healthcare provider [other than already disclosed]? [Do NOT include annual physical exams.] $\square$ Yes	□ No]
[17.] [Had any testing [with abnormal findings] or tests for which you have not received results [other than already disclosed]?	□ No]
[18.] [Been recommended or scheduled for diagnostic testing, consultations, treatment, follow-up or surgery that has not been completed?	□ No]
[19.] [Received or recommended to have any treatment for alcoholism, alcohol or drug abuse or addiction, including but not limited to, counseling or attendance at support groups?	□ No]
[20.] [Used illegal drugs or prescription medication other than as prescribed or been advised by a physician or health care provider to discontinue or decrease alcohol consumption or drug use? □ Yes	□ No]
Additional Questions	
[21.] [Has any proposed insured taken or been advised to take any prescription medication in the last [[10] years] [[12] months]?	□ No]
[22.] [Has any proposed adult [ever] used tobacco products in any form or nicotine substitutes [within the last [10] years] [after the age of [21]]?	□ No]
[23.] [Has any proposed insured had a diagnosis, [[or] treatment] [or follow-up] for cancer in the last [10] years?	□ No]
[24.] [Is any proposed insured currently pregnant, an expectant parent or in the process of adoption or surrogate pregnancy? [This includes a surrogate mother or any person	
that she is contracted with.]	
[25.] [Have you fully disclosed all medical conditions for you and your family within the last [10] years? $\Box$ Yes	⊔ No]
REQUESTING THE REMOVAL OF A SPECIAL CLASS PREMIUM, SPECIAL EXCEPTION RIDER OR CONDITION SPECIFIC DEDU	CTIBLE
[26.] [Has there been any medical treatment or medication use for, or have you consulted with a physician or healthcare provider concerning the condition(s) which has had a Condition Specific Deductible, been ridered or rated since the covered person's effective date?	□ No] ]

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#### **ADDITIONAL NOTICES**

#### [NOTIFICATION REGARDING [MIB, Inc.] [("MIB")] [formerly known as the Medical Information Bureau]

Information regarding your insurability will be treated as confidential. Time Insurance Company or its reinsurers may, however, make a brief report thereon to [the] [MIB, Inc.,] [formerly known as Medical Information Bureau], a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another [MIB] member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, [MIB], upon request, will supply such company with the information in its file.

Upon receipt of a request from you, [MIB] will arrange disclosure of any information it may have in your file. Please contact [MIB] at [866 692-6901] [(TTY 866 346-3642)]. If you question the accuracy of information in [MIB's] file, you may contact [MIB] and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of [MIB's] information office is [50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734].

Time Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life, or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about [MIB] may be obtained on its website at [www.mib.com].]

#### ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

To issue an insurance policy or certificate, we need to obtain information about you and any other person proposed for insurance. Some of that information will be received from you, and some will be generated from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact Time Insurance Company, Underwriting Department, 501 West Michigan, Milwaukee, Wisconsin, 53203.

#### FRAUD NOTICE

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Division of Insurance within the Department of Regulatory Agencies.

#### **PRIVACY**

We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted by law. We collect non-public information about you from the following sources: (1) information we receive from you on enrollment forms or other information related thereto or as part of policy administration, and (2) information about your transactions with our affiliates, others or us. We restrict access to non-public personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your non-public personal information. We may disclose non-public personal information about you to nonaffiliated third parties as permitted by law.

ADDITIONAL NOTES	

#### [HIPAA ELIGIBILITY

[Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), certain individuals have a guaranteed right to an individual plan without a pre-existing exclusion. In order for Time Insurance Company to determine whether you or anyone applying for coverage is entitled to such a plan, please review the following and indicate whether ALL of the following statements are true at the time you or anyone to be insured apply for individual coverage:

- You have at least 18 months of continuous creditable coverage without any break in coverage greater than 63 days.
- Your most recent coverage was under a group plan, a governmental plan or a church plan.
- You are not covered under another group health plan.
- Your most recent coverage was not cancelled because you did not pay premiums or because you committed fraud.
- You are not currently eligible for Medicare or Medicaid.
- You have exhausted any continuation of coverage (COBRA or state continuation) for which you were eligible.
- $\square$  No, I or anyone to be insured do not meet one or more of the foregoing requirements.
  - Yes, I or anyone to be insured meet all of the foregoing requirements.]

#### **EMPLOYER SPONSORED BUSINESS (ESB) STATEMENT**

#### **AUTHORIZATION**

In order to determine my (our) eligibility for insurance, I authorize any licensed physician, medical practitioner, hospital, clinic, any pharmacy, pharmacy benefit manager or pharmacy-related entity, any medically-related facility, insurance company, the Medical Information Bureau, employer, or consumer-reporting agency to give Time Insurance Company (or any consumer-reporting agency authorized by Time Insurance Company) any information regarding me or my family as to employment, other insurance coverage, personal information, and medical or pharmacy care, advice or treatment, or medication use.

I represent to the best of my knowledge and belief, that all statements and answers on Part 1 are complete and true. My recorded Personal Health History, Part 1 and any amendments shall be the basis for the contract. I also agree that: (1) I must call Time Insurance Company and complete the Personal Health History portion of the enrollment process within 10 days of commencement of the enrollment process and subsequently provide any and all medical information related thereto. (2) Within 30 days of policy delivery, I must formally accept the offer by verifying the accuracy of the enrollment form information with a signature and returning that signed acceptance to Time Insurance Company. (3) Except as otherwise provided in the Conditional Receipt, the insurance, if approved by Time Insurance Company, will be in force only when issued by Time Insurance Company and accepted by me. (4) I understand and agree that any information I provide through this application process may be shared with persons necessary to facilitate issuing coverage, including but not limited to my agent or broker. (5) If any of these conditions are not met, Time Insurance Company has the right to rescind its offer of coverage and the full extent of its liability shall be limited to the sum received.

[I hereby authorize any health care provider or medically related facility, pharmacy or pharmacy related facility, the Medical Information Bureau, Inc., consumer reporting agency, insurance or reinsurance company or employer having information about me or my minor children to provide all such information as may be requested to Time Insurance Company, its legal representative or any medical records retrieval service Time Insurance Company may engage, including, but not limited to, EMSI and its agents.]

[This authorization includes any and all information you may have about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, prescription history, lab data and EKGs. This information may also be disclosed to the Medical Information Bureau, Inc. and any medical records company engaged by Time Insurance Company, including but not limited to EMSI and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Time Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. A copy of this authorization will be valid as an original.]

[I understand that this authorization is required in order to enable Time Insurance Company to make eligibility or enrollment determinations relating to me and/or my minor children or for Time Insurance Company's underwriting or risk rating determinations. If I refuse to sign or revoke this authorization, Time Insurance Company may refuse to consider my application for enrollment.]

[I understand that I may revoke this authorization at any time by notifying Time Insurance Company in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, Time Insurance Company, P.O. Box 3050, 501 West Michigan, Milwaukee, WI 53201-3050. Such revocation will not be valid if Time Insurance Company has taken action in reliance on the authorization.]

[Unless an earlier date is required by law, this authorization expires upon the earliest of the following events: [30] days after denial of my application, or declination of enrollment, or, if insured, [30] days after when I am no longer an insured of Time Insurance Company. But in no event will this authorization be in effect for longer than [24] months from the date signed.]

Signature of Primary Proposed Insured	Date	e Signed	A.M./P.M. Time Signed	City	State
Signature of Spouse[/Domestic Partner] [/O or Other (if proposed to be insured)	Civil Union]	-	e(s) of Other Depend osed to be insured)	ent(s) 18 or Over	
Guardian's Signature					
Requested Effective Date:	Premium Amount Sent: \$		One-time Pr	ocessing Fee Sent*:	



# **Preferred Rating Questionnaire**

Complete this questionnaire to determine eligibility for the [Preferred] or [Preferred Smoker] rating classes.

Primary Proposed Insured's Name (please print)

[\*Note: A proposed insured may be eligible for a Preferred Smoker rating if he or she is able to truthfully answer questions [2,] [3] [and] [4] "No." Underwriting reserves the right to apply tobacco ratings based upon lab results, phone verification or medical records.]

Each proposed insured must complete and sign the appropriate sections. Spouses[/Other Insured] are considered separately for preferred rating eligibility and must also answer this questionnaire. This information is not required for dependents.

			PRIMARY	SPOUSE [/OTHER INSURED]
[1.] [Has the proposed insured used to during the past [3] years? (If NO,	•	ny time	☐ Yes ☐ No	☐ Yes ☐ No]
[2.] [Did the proposed insured previous smoke [10] or more cigarettes per	•	currently	☐ Yes ☐ No	☐ Yes ☐ No]
[3.] [Did the proposed insured previous more than [1] cigar or pipe per da		currently smoke	☐ Yes ☐ No	☐ Yes ☐ No]
[4.] [Did the proposed insured previous chewing tobacco?	sly use or do they cu	rrently use	☐ Yes ☐ No	☐ Yes ☐ No]
[5.] [Is the proposed insured currently build chart?	outside the weight r	ange listed in the	☐ Yes ☐ No	☐ Yes ☐ No]
[6.] [Has the proposed insured had blo or been treated for elevated bloo	,		0]	☐ Yes ☐ No]
[7.] [Has the proposed insured had che cholesterol/HDL ratio above [3.5] or triglycerides within the past [1	or been treated for		☐ Yes ☐ No	☐ Yes ☐ No]
[8.] [Has the proposed insured had any citations for DUI or more than [1] moving violation including speeding ticket(s) within the past [2] years?			g □ Yes □ No	☐ Yes ☐ No]
[9.] [Has the proposed insured had a c [3] years?**	complete physical exa	am within the past	☐ Yes ☐ No	☐ Yes ☐ No]
** Individuals age [40] and over must have had	a physical exam in the pa	st [3] years to qualify for p	oreferred rates.	
Primary Proposed Insured Signature	Date	Spouse or Other Insure	ed Signature	Date
[Driver's License Number]		[Driver's License Num	ber]	
Licensed Agent Signature	Date	Agent Number		



Time Insurance Company 501 W. Michigan Street [P.O. Box 624] Milwaukee, WI 53201-0624 [800-800-1212]

# AMENDMENT OF APPLICATION/ENROLLMENT FORM

I, [John Doe], hereby amend my application/enrollment form to Time Insurance Company dated [December 03, 2009] as follows:

[Insert Amendment Verbiage Here.]

#### \*\*\*PLEASE READ AND COMPLETE THE FOLLOWING:\*\*\*

I hereby represent that the above statements are true and complete to the best of my knowledge and belief. I agree that this form shall be an amendment to the original application/enrollment form and of any [policy]/[certificate] issued hereunder. I also agree that no coverage shall be in effect until this form shall have been completed and the full premium paid.

Accepted at:				
City or Town,		State.	Date.	
Signature of Insured (listed above):	X			
		[John Doe] (If minor, legal gu	ardian signature needed)	-
[Signature of Owner/Primary Insured:]		[		]
	•	[(If minor, legal gu	ardian signature needed)]	
[Agent's Signature:]	X	[		]
Policy/Certificate No. [000012345]				